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ABSTRACT

This monograph explores the development of comprehensive systems of care for severely emotionally disturbed children and adolescents. It is intended as a technical assistance tool for states and communities interested in improving services and as a review of the state of the art for developing systems of care. A generic model of a system of care is presented, along with principles for service delivery and alternative system management approaches. The components of the system of care include mental health services, social services, educational services, health services, vocational services, recreational services, and operational services. Management of the system of care involves consideration of state-community relationships, alternative models for system management, and the role of case management and case review committees. Assessment of the characteristics of an effective system is also featured, and worksheets to assess the status of the system of care are provided. References accompany each chapter. (JDD)

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A System of Care for Severely Emotionally Disturbed Children & Youth

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A SYSTEM OF CARE
FOR SEVERELY EMOTIONALLY DISTURBED CHILDREN & YOUTH

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ACKNOWLEDGEMENTS

This monograph represents the culmination of a project spanning nearly two years. It has been an ambitious undertaking to develop and describe a model system of care for severely emotionally disturbed children and adolescents, one which could not have been accomplished by the authors alone. At various stages many individuals have participated in and contributed to the project. The authors would like to take this opportunity to acknowledge their contributions.

First, the project has been undertaken collaboratively by the CASSP Technical Assistance Center at the Georgetown University Child Development Center and the Florida Research and Training Center for Improved Services for Seriously Emotionally Disturbed Children at the Florida Mental Health Institute. The leadership and staff of both centers have contributed their guidance, suggestions and support. The special contribution of Al Duchnowski, Ph.D. of the Florida Research and Training Center is gratefully acknowledged, along with the contributions of Melinda Allegar, Krista Kutash and Sue Street, Ph.D. The editorial assistance of Adele Shapiro and Sidney Shapiro is appreciated.

The Advisory Committee to the CASSP Technical Assistance Center at Georgetown University played a special role in this project. The need to define what a system of care for emotionally disturbed children should include and how such a system might be organized was highlighted by the Advisory Committee at its initial meeting. Thus, the genesis of the idea for the "system of care project" can be attributed to this group. In July, 1985 the Advisory Committee devoted a major portion of its meeting to the system of care project, and the framework for the system of care which is described in this document was developed at that time.

The State Mental Health Representatives for Children and Youth (SMHRCY) have also been closely involved in the system of care project, and have offered their insights and suggestions at key project junctures. A subgroup of SMHRCY Representatives participated in the formulation of the system of care framework and guiding principles.

Special thanks to those individuals who lent their time and expertise to review and comment on the draft of this monograph. Their comments and concerns have been incorporated into the monograph, and they have ensured that a wide range of perspectives have been considered in developing the final product. These individuals include Lenore Behar, Ph.D., Suzanne Bronheim, Ph.D., William Buzogany, M.D., Paul Carling, Ph.D., Martha Forbes, Barbara Friesen, Ph.D., Sybil Goldman, Mareasa Isaacs, Ph.D., Jane Knitzer, Ed.D., Phyllis Magrab, Ph.D., Doug McCoard, Matthew Modrcin, Ph.D., M. R. Newton, John VanDenBerg and Christina Young.

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PREFACE

In 1982, the National Institute of Mental Health and the State Mental Health Representatives for Children and Youth (a Division of the National Association of State Mental Health Program Directors) jointly sponsored a meeting to explore the needs of severely emotionally disturbed children and youth. The participants included state and Federal officials who were working with this population, researchers, advocates and service providers. The meeting resulted in a series of recommendations for how this population should be defined, what kinds of services were required, how the service system should be constructed and the type of advocacy necessary to promulgate changes in the child service system. A major task of this effort was to begin to define the concept of a "continuum of care" for severely emotionally disturbed children and youth. The "continuum of care," as defined through this effort, encompassed a range of service options that needed to be available and accessible in order to appropriately meet the multiple service needs of severely emotionally disturbed children.

The gaps in service options and the failure of the present systems to meet the needs of seriously emotionally disturbed children have become increasingly evident. Jane Knitzer's seminal study, Unclaimed Children, documented the state of service system delivery throughout the country and the continuing failure of these systems to provide adequate care.

In 1984, Congress responded to the call for change and funded an initiative to demonstrate the development of better functioning service systems. This effort led the National Institute of Mental Health to develop the Child and Adolescent Service System Program (CASSP). This program supports states in the development of interagency efforts to improve the systems under which the most troubled children and youth receive service.

For several years, CASSP, through a series of 24 state grants, has been promoting both concepts and strategies for changing the service system in order to more responsively meet the multiple needs of severely emotionally disturbed children and youth. The conceptual framework focuses on the need for interagency collaboration and coordination across systems in delivering services to this greatly underserved and inappropriately served population.

The exploration of children's service delivery has led to certain questions whose answers are vital to the development of meaningful programs. They are:

- What should a service system for seriously emotionally disturbed children and youth encompass?
- Toward what new configuration or ideal should service system change be directed?
- What are the components of the system?
- What is the ultimate goal of such systems change?

The answers to these questions will be helpful to all those who are interested in changing how services are delivered, what services are delivered and where services are delivered to severely emotionally disturbed children and youth. The information presented in this volume describes the various service options required by these youth, and leads the way for the development of continuums of care across all of the relevant child-serving agencies. From this, a greater "System of Care," encompassing the full range of services and the mechanisms required for the assurance of their appropriate delivery, can be developed.

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EXECUTIVE SUMMARY

In her book Unclaimed Children, Knitzer (1982) reported that two-thirds of all severely emotionally disturbed children and youth do not receive the services they need. Many others receive inappropriate, often excessively restrictive care. Recently, there has been increasing activity to improve services for severely emotionally disturbed children and adolescents. The National Institute of Mental Health (NIMH) launched the Child and Adolescent Service System Program (CASSP) to assist states and communities to develop comprehensive, community-based systems of care, and coalitions of policymakers, providers, parents and advocates are being forged to promote the development of such systems of care.

This monograph explores the development of comprehensive systems of care for severely emotionally disturbed children and adolescents. The preparation of the monograph was sponsored by CASSP, and the document represents the final product of a collaborative process undertaken by the CASSP Technical Assistance Center at Georgetown University and the Florida Research and Training Center for Improved Services for Seriously Emotionally Disturbed Children at the Florida Mental Health Institute.

The monograph is intended as a technical assistance tool for states and communities interested in improving services for emotionally disturbed children, and as a review of the state of the art for developing systems of care. A generic model of a system of care is presented along with principles for service delivery and alternative system management approaches. This model offers a conceptual framework to provide direction to policymakers, planners and providers. It is expected that states and communities will modify and adapt the model to their particular environments, and will establish priorities for system development in accordance with their needs.

BACKGROUND

The Joint Commission on the Mental Health of Children (1969) found that millions of children and youth were not receiving needed mental health services. Many of the children that were served received inappropriate, unnecessarily restrictive care, often in state mental hospitals. The President's Commission on Mental Health (1978) echoed the Joint Commission's conclusions, finding that few communities provided the volume or continuum of programs necessary to meet children's mental health needs. Both Commissions recommended that an integrated network of services be developed in communities to meet the needs of severely emotionally disturbed children and youth. Knitzer (1982) asserted that the needs of severely emotionally disturbed children have remained largely unaddressed. She considers these children to be "unclaimed" by the public agencies with responsibility to serve them.

These reports and others have made it apparent that the range of mental health and other services needed by severely emotionally disturbed children and adolescents is frequently unavailable. Many children are institutionalized when less restrictive, community-based services would be more effective. Additionally, there have been few attempts to get mental health, child welfare, juvenile justice, health and education agencies to work together on behalf of disturbed children and youth. This has left children and youth with serious and complex problems to receive services in an uncoordinated and piecemeal fashion, if at all.

Currently, there is broad agreement about the critical need to improve both the range and coordination of services delivered to severely emotionally disturbed children and their families. The development of comprehensive, coordinated "systems of care" for children and youth has become a national goal.

The term "continuum of care" has been used extensively in the field to describe the range of services needed by severely emotionally disturbed children and adolescents. In fact, much of the published literature and many of the materials produced by states use this term. Throughout this document, the term "system of care" is employed. Before proceeding to describe the system itself, definitions of these terms are required, along with the rationale for using the latter term.

"Continuum of care" generally connotes a range of services or program components at varying levels of intensity. These are the actual program elements and services needed by children and youth. "System of care" has a broader connotation. It not only includes the program and service components, but also encompasses mechanisms, arrangements, structures or processes to insure that the services are provided in a coordinated, cohesive manner. Thus, the system of care is greater than the continuum, containing the components **and** provisions for service coordination and integration.

A system of care, therefore, is defined as follows:

> **A system of care is a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of severely emotionally disturbed children and adolescents.**

This monograph describes how these systems of care might look and how they might be organized.

SEVERELY EMOTIONALLY DISTURBED CHILDREN AND THEIR NEEDS

The Federal CASSP initiative is focused on severely emotionally disturbed youngsters whose problems are so severe as to require the long-term intervention of mental health and other agencies. To assist states and communities in identifying this population, NIMH developed a set of basic parameters for defining the target population (Stroul, 1983).

As these parameters indicate, the designation of "severe emotional disturbance" among children should be primarily based on functional disabilities which are of significant severity and duration, and on the need for a broad range of services. This set of general criteria is designed to guide the system building efforts of states, while allowing states the flexibility to develop more specific definitions. Several states have developed such definitions.

The prevalence of severe emotional disturbance among children and youth is difficult to determine. The primary reasons for this are the lack of agreement about the definition of "severe emotional disturbance," the difficulty in measuring the socio-emotional disturbances, and the great cost and practical obstacles in conducting epidemiological research in children's mental health.

Based on a review of a number of epidemiological studies, Gould, Wunsch-Hitzig & Dohrewend (1981) estimated that the prevalence of "clinical maladjustment" among children is at least 11.8 percent. Despite methodological inconsistencies and deficiencies in the research, the estimate by Gould et al. of 11.8 percent appears to be a reasonable, if not somewhat conservative, estimate.

A subset of this group of children showing emotional problems can be considered severely emotionally disturbed. From a review of existing prevalence research, Knitzer (1982) concluded that a conservative estimate of serious emotional disturbance in children is five percent or approximately three million youngsters. In the description of CASSP, NIMH (1983) has adopted the same figure. While this figure is not firmly based empirically, it appears to be generally consistent with the research and reasonable as an estimate. It should be kept in mind that this five percent estimate includes only youngsters whose problems are severe and persistent, while the 11.8 percent estimate includes all emotionally disturbed youngsters.

While differences around definition and prevalence may persist, there is greater consensus about the needs of severely emotionally disturbed children. These children require a range of mental health services which are age appropriate and at varying levels of intensity. However, mental health services alone are not enough. Emotionally disturbed children almost universally manifest problems in many spheres including home, school and community. As a result, they require the intervention of other agencies and systems to provide special education, child welfare, health, vocational and, often, juvenile justice services.

Thus, the needs of severely emotionally disturbed children and youth cannot be met by the mental health system in isolation. A comprehensive array of mental health and other services are required to meet their needs. The conclusions of nearly all commissions and experts converge in recommending a multiagency, multidisciplinary system of services for emotionally disturbed children and their families.

Although comprehensive systems of care for emotionally disturbed children have been recommended for some time, progress in developing such systems has been slow. At present, there are serious gaps both in terms of the mental health services that are available to children and their families and the other essential services. Where such gaps in actual service do not exist, the lack of coordination between agencies seriously limits the effectiveness of individual service components. The consequence of these system deficiencies is that treatment is often inadequate and fragmented.

The situation is complicated by an overreliance on more expensive and more restrictive services than are actually needed. Behar (1984) reports a strong tendency to remove children from their families and natural environments with the belief that effective treatment can only be accomplished in a residential setting. Knitzer (1982) identified efforts to increase residential care in almost half of the states, while nonresidential services remained either nonexistent or rudimentary. Thus, residential services appear to be overutilized, although recent experience indicates that intensive services in the home and school may reduce the need for residential care (Friedman and Street, 1985). When residential care is indicated, less restrictive, community-based alternatives such as therapeutic foster care are often neglected in favor of institutionally-based services.

While these problems remain, there are indications of progress in services for severely emotionally disturbed children. The need for comprehensive, community-based systems of service that incorporate a wide range of different services is receiving more and more recognition. Isaacs (1983, 1984) found that a number of states have identified children's mental health as one of their top mental health priorities, and many states are now initiating system development activities. Nearly half the states in the nation are now involved in the CASSP initiative, and both funded and unfunded states are participating in technical assistance activities related to system of care development such as regional and national conferences. It seems clear that interest in developing comprehensive systems of care has increased markedly.

PRINCIPLES FOR THE SYSTEM OF CARE

The system of care for severely emotionally disturbed children and adolescents represents more than a network of service components. Rather, the system of care represents a **philosophy** about the way in which services should be delivered to children and their families. The actual components and organizational configuration of the system of care may differ from state to state and from community to community. Despite such differences, the system of care should be guided by a set of basic values and operational philosophies.

Not surprisingly, there is general agreement in the field and in the literature as to the values and philosophy which should be embodied in the system of care for severely emotionally disturbed youth. With extensive consultation from the field, two core values and a set of 10 principles have been developed to provide a philosophical framework for the system of care model.

The two core values are central to the system of care and its operation. The first value is that the system of care must be driven by the needs of the child and his or her family. In other words, the system of care must be **child-centered**, with the needs of the child and family dictating the types and mix of services provided. This child-centered focus is seen as a commitment to adapt services to the child and family, rather than expecting children and families to conform to pre-existing service configurations. It is also seen as a commitment to providing services in an environment and a manner that enhances the personal dignity of children and families, respects their wishes and individual goals, and maximizes opportunities for involvement and self-determination in the planning and delivery of services.

The second core value holds that the system of care for emotionally disturbed children should be **community-based**. Historically, services for this population have been limited to state hospitals, training schools and other restrictive institutional facilities. There has been increasing interest and progress in serving such children in community-based programs which provide less restrictive, more normative environments. The system of care embraces the philosophy of a community-based network of services for emotionally disturbed youth and families. While "institutional" care may be indicated for certain children at various points in time, in many cases appropriate services can be provided in other, less restrictive settings within or close to the child's home community.

In addition to these two fundamental values for the system of care, 10 principles have been identified which enunciate other basic beliefs about the optimal nature of the system of care. The values and principles are displayed on the following page, and each principle is discussed within the monograph.

SYSTEM OF CARE FRAMEWORK AND COMPONENTS

The system of care model presented in this document represents one approach to a system of care. No single approach has as yet been adequately implemented and tested to be considered the ideal model. The model presented is designed to be a

CORE VALUES FOR THE SYSTEM OF CARE

1. The system of care should be child-centered, with the needs of the child and family dictating the types and mix of services provided.

2. The system of care should be community-based, with the locus of services as well as management and decision-making responsibility resting at the community level.

GUIDING PRINCIPLES FOR THE SYSTEM OF CARE

1. Emotionally disturbed children should have access to a comprehensive array of services that address the child's physical, emotional, social and educational needs.

2. Emotionally disturbed children should receive individualized services in accordance with the unique needs and potentials of each child, and guided by an individualized service plan.

3. Emotionally disturbed children should receive services within the least restrictive, most normative environment that is clinically appropriate.

4. The families and surrogate families of emotionally disturbed children should be full participants in all aspects of the planning and delivery of services.

5. Emotionally disturbed children should receive services that are integrated, with linkages between child-caring agencies and programs and mechanisms for planning, developing and coordinating services.

6. Emotionally disturbed children should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner, and that they can move through the system of services in accordance with their changing needs.

7. Early identification and intervention for children with emotional problems should be promoted by the system of care in order to enhance the likelihood of positive outcomes.

8. Emotionally disturbed children should be ensured smooth transitions to the adult service system as they reach maturity.

9. The rights of emotionally disturbed children should be protected, and effective advocacy efforts for emotionally disturbed children and youth should be promoted.

10. Emotionally disturbed children should receive services without regard to race, religion, national origin, sex, physical disability or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.

guide, based on the best available empirical data and clinical experience to date. It is offered as a starting point for states and communities as they seek to build their systems, as a baseline from which changes can be made as additional research, experience and innovation dictate.

While individuals may wish to examine the services in their own states and communities in relation to the system presented here, the information is not intended to be used as a checklist. The desired system in a particular community is dependent, in part, upon community characteristics such as population, physical size, proximity to other communities, unique resources and special features of the population. Not every community is expected to have every service in place. The model is not a prescription, but rather should serve as a guide for communities, with the expectation that it will be modified and adapted to meet special conditions and needs.

States and communities are also expected to establish different system development priorities. An approach frequently used involves defining a core or minimal set of services as the first priority for system of care development efforts. When goals in relation to this core set of services are achieved, states and communities may then begin to develop an expanded array of service options.

The system of care model is organized in a framework consisting of seven major dimensions of service, each dimension representing an area of need for children and their families. The framework is graphically presented on page ix, and includes the following dimensions:

1. Mental health services

2. Social services

3. Educational services

4. Health services

5. Vocational services

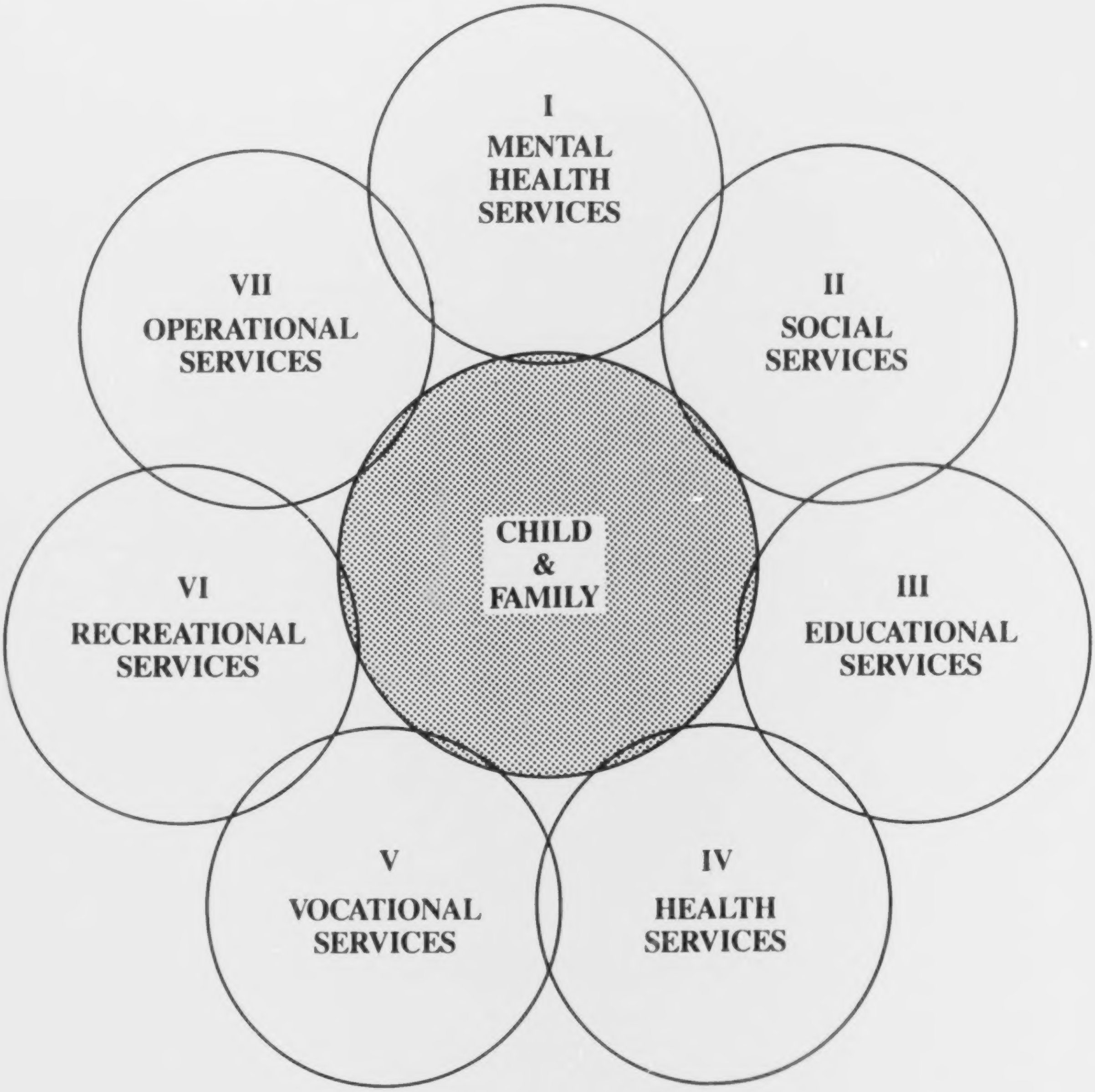
6. Recreational services

7. Operational services

The system of care model is intended to be **function-specific** rather than agency-specific. Each service dimension addresses an area of need for children and families, a set of functions that must be fulfilled in order to provide comprehensive services to meet these needs. The model is **not** intended to specify which type of agency should fulfill any of the particular functions or needs. Certainly, particular agencies typically provide certain of these services in communities. Educational services, for example, are most often provided by school systems, and social services are generally associated with child welfare or social welfare agencies. One might assume that the mental health services should be provided by mental health agencies. This, however, is often not the case.

All of the functions included in the system of care dimensions may be fulfilled by a variety of agencies or practitioners in both the public and private sectors. Therapeutic group care, a component in the mental health dimension, is often fulfilled by juvenile justice agencies and social service agencies as well as by mental health

SYSTEM OF CARE FRAMEWORK


I
MENTAL HEALTH SERVICES
II
SOCIAL SERVICES
III
EDUCATIONAL SERVICES
IV
HEALTH SERVICES
V
VOCATIONAL SERVICES
VI
RECREATIONAL SERVICES
VII
OPERATIONAL SERVICES
CHILD & FAMILY

agencies. Day treatment is another mental health function that is frequently fulfilled by the educational agencies, ideally in close collaboration with mental health providers.

While the roles and responsibilities of specific agencies are acknowledged, an effective system of care should be based on child and family needs primarily, rather than on agency features. Many of the services to be described can be, and are, provided by different agencies in different communities.

Furthermore, many of these services are provided not through the efforts of any single agency but through multiagency collaborative efforts. Such collaborations are important not only in identifying needs and planning services but also in developing, funding and operating services.

It should also be recognized that services are not always provided by agencies. Some functions within the system of care may be fulfilled by families, parent cooperatives or other such arrangements. Private sector facilities and practitioners can also play a pivotal role in the system of care, providing a wide range of services within each of the major dimensions.

Juvenile justice agencies play an important role in the system of care. The juvenile justice system provides a wide range of services to children and adolescents who have broken the law. While the juvenile justice system has an interest in helping children and families, its mission is also to meet the needs of the community and society. This mission is accomplished through measures to control troublesome or delinquent behavior (Shore, 1985). Many juvenile offenders can be considered emotionally disturbed, and the juvenile justice system plays a critical role in serving emotionally disturbed juvenile offenders. Juvenile justice agencies provide or collaborate with other agencies to offer many of the system of care components to this subgroup. Among the components frequently provided by juvenile justice agencies are outpatient services, therapeutic foster and group care and residential treatment. The critical role of the juvenile justice system in serving emotionally disturbed juvenile offenders must be acknowledged as well as its special role in the system of care.

An important aspect of the concept of a system of care is the notion that all components of the system are interrelated, and that the effectiveness of any one component is related to the availability and effectiveness of all other components. For example, the same day treatment service may be more effective if embedded in a system that also includes good outpatient, crisis and residential treatment, than if placed in a system where the other services are lacking. Similarly, such a program will be more effective if social, health, and vocational services are also available in the community than if they are absent or of low quality. In a system of care, all of the components are interdependent--not only the components within a service dimension such as mental health, but all of the seven service dimensions that comprise the model.

A critical characteristic of an effective system is an appropriate balance between the components, particularly between the more restrictive and less restrictive services. If such balance is not present, then youngsters and families will not have a full chance to receive less restrictive services before moving to more restrictive services. If, for example, within a community there are no intensive home-based services, only 20 day treatment slots and 50 residential treatment slots, the system is not in balance. Youngsters and families will most likely not have the opportunity to participate in home-based or day treatment services because of their relative unavailability, and the residential components of the system will be overloaded with youngsters, some of whom might have been diverted from residential treatment if there had been more nonresidential services available.

At the present time there are no clear, empirically-based guidelines about the appropriate capacity within each component of a system of care. As a consequence, no specific quantitative guidelines are presented in this document. Implicit within a model system of service, however, is the expectation that more youngsters will require the less restrictive services than the more restrictive ones, and that service capacity should, therefore, diminish as one proceeds through the system. In particular, the system capacity in the more intensive of the nonresidential services should exceed the system capacity in the residential service components. As additional research and field experience are accumulated with respect to systems of care for severely emotionally disturbed children, it may become possible to define the optimal ratios of capacities in the different system components.

Within each of the seven service dimensions is a continuum of service components. These dimensions and the components within them are displayed on the following page, and are described within the monograph. The major focus, however, is on the continuum of mental health services since these are critical services for all severely emotionally disturbed children. While the mental health dimension is described in some detail, brief descriptions are provided with respect to the other dimensions. These descriptions are intended as introductions to the service dimensions, and not as comprehensive reports on all the services included in the system of care.

Throughout the discussion of the individual services, it should be recalled that these are component parts of an overall system of care. The boundaries between the various dimensions and components are not always clear, and frequently there is overlap among them. While they are described individually, the system of care dimensions and service components cannot be operated in isolation. Only when the services are enmeshed in a coherent, well-coordinated system will the needs of severely emotionally disturbed youngsters and their families be met in an appropriate and effective manner.

The mental health services of the system of care are shown on page xiii. They are divided into seven nonresidential categories, and seven residential categories. The components often overlap to some degree. For example, the difference between therapeutic group care and residential treatment is not always clearly distinguishable. Further, there are a variety of different program models for each component, such as several distinct approaches to therapeutic foster care. Some of these different models are noted in the discussion of the components in the monograph.

The operational services dimension is somewhat different from the other system of care dimensions. This dimension includes a range of support services that can make the difference between an effective and an ineffective system of care, but do not fall into a specific category. Instead, they tend to cross the boundaries between different types of services. They are called "operational services" because of their importance to the overall effective operation of the system. The services included in this dimension are case management, self-help and support groups, advocacy, transportation, legal services and volunteer programs.

Case management is an essential service that can play a critical role in the system of care. Behar (1985) calls case management "perhaps the most essential unifying factor in service delivery." This indicates the important role that case management can play

COMPONENTS OF THE SYSTEM OF CARE

1. MENTAL HEALTH SERVICES

Nonresidential Services:
Prevention
Early Identification & Intervention
Assessment
Outpatient Treatment
Home-Based Services
Day Treatment
Emergency Services

Residential Services:
Therapeutic Foster Care
Therapeutic Group Care
Therapeutic Camp Services
Independent Living Services
Residential Treatment Services
Crisis Residential Services
Inpatient Hospitalization

2. SOCIAL SERVICES

Protective Services
Financial Assistance
Home Aid Services
Respite Care
Shelter Services
Foster Care
Adoption

3. EDUCATIONAL SERVICES

Assessment & Planning
Resource Rooms
Self-Contained Special Education
Special Schools
Home-Bound Instruction
Residential Schools
Alternative Programs

4. HEALTH SERVICES

Health Education & Prevention
Screening & Assessment
Primary Care
Acute Care
Long-Term Care

5. VOCATIONAL SERVICES

Career Education
Vocational Assessment
Job Survival Skills Training
Vocational Skills Training
Work Experiences
Job Finding, Placement & Retention Services
Supported Employment

6. RECREATIONAL SERVICES

Relationships with Significant Others
After School Programs
Summer Camps
Special Recreational Projects

7. OPERATIONAL SERVICES

Case Management
Self-Help & Support Groups
Advocacy
Transportation
Legal Services
Volunteer Programs

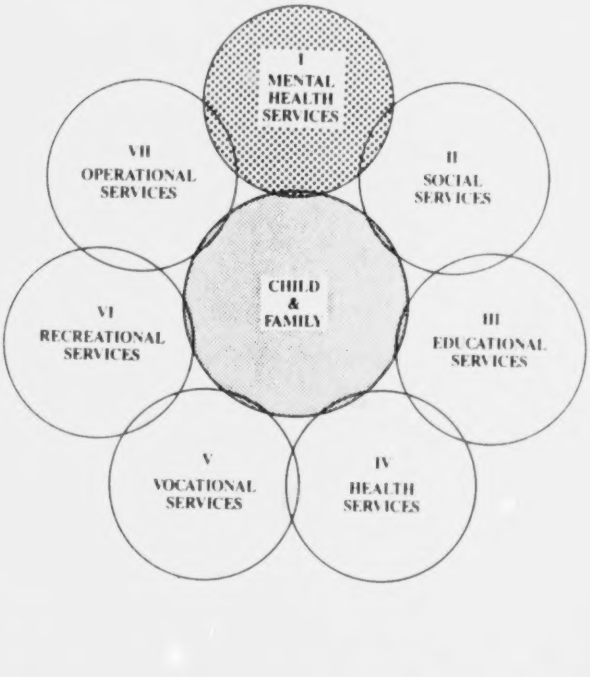
DIMENSION I: MENTAL HEALTH SERVICES

NONRESIDENTIAL SERVICES:

- PREVENTION
- EARLY IDENTIFICATION & INTERVENTION
- ASSESSMENT
- OUTPATIENT TREATMENT
- HOME-BASED SERVICES
- DAY TREATMENT
- EMERGENCY SERVICES

RESIDENTIAL SERVICES:

- THERAPEUTIC FOSTER CARE
- THERAPEUTIC GROUP CARE
- THERAPEUTIC CAMP SERVICES
- INDEPENDENT LIVING SERVICES
- RESIDENTIAL TREATMENT SERVICES
- CRISIS RESIDENTIAL SERVICES
- INPATIENT HOSPITALIZATION


I MENTAL HEALTH SERVICES
II SOCIAL SERVICES
III EDUCATIONAL SERVICES
IV HEALTH SERVICES
V VOCATIONAL SERVICES
VI RECREATIONAL SERVICES
VII OPERATIONAL SERVICES
CHILD & FAMILY

in a system of service, a role that has been increasingly recognized in recent years but has only been operationalized in a few states.

Case management serves youngsters involved in both residential and nonresidential programs. It involves brokering services for individual youngsters, advocacy on their behalf, insuring that an adequate treatment plan is developed and is being implemented, reviewing client progress and coordinating services. Case management involves aggressive outreach to the child and family, and working with them and with numerous community agencies and resources to ensure that all needed services and supports are in place.

Advocacy can also play a critical role in the system of care. There are two basic types of advocacy. The first is "case" advocacy, or advocacy on behalf of the needs of individual children. Effective case advocates must be knowledgeable about the workings of the service systems which serve children, and must be skilled in making these systems more responsive to the needs of individual children. Case managers perform case advocacy functions, but other professionals, citizen advocates and parents can fulfill this role as well.

The second type of advocacy is "class" advocacy, or advocacy on behalf of a group of individuals. Class advocacy, if successful, can have a greater impact than case advocacy because it can produce changes that affect more children (Knitzer, 1984). Class advocacy is typically a lengthy process that requires not only considerable knowledge and skill, but also enormous persistence.

Efforts to advocate for improved services are beginning to take the form of coalitions of parent, provider, professional and voluntary advocacy organizations. These coalitions are forming at community, state and national levels, and have potential for exercising considerable influence over policies and services.

The increased interest in advocacy is one of the more encouraging signs in the children's mental health field in recent years. A key issue affecting the degree to which effective systems of care will be developed is the extent to which strong, persistent and well-targeted advocacy efforts can be developed at the community, state and national levels.

MANAGEMENT OF THE SYSTEM OF CARE

The development of strong components is undoubtedly the most important aspect of developing an effective system. Another important aspect, however, is insuring that the system is managed in a clear and consistent way to assure that youngsters and families receive the services they need in a coherent and coordinated manner.

Proper system management should insure good coordination between components of the system. Such coordination is necessary because most youngsters require services from more than one component at a particular point in time. Only in a well-managed system would it be possible for one youngster to receive all of these needed services, and particularly to receive them in a manner that produces coordinated efforts by different professionals and agencies to achieve the same goals. Effective system management should also insure that as a child's needs change, he or she will be able to easily move into different services, or that existing services will adapt to the new needs.

A major issue with respect to system management is the relationship between state level and community level agencies in managing the system. This includes such questions as the extent to which fiscal resources are controlled at the state level or community level, the degree of flexibility that communities are allowed to develop systems tailored to meet the specific needs within their area, and the degree to which decision making takes place at the community level versus the state level.

In order for the system to be able to be most responsive to the needs of the child and family, the community should most logically be responsible for system management and coordination. However, the state must also play a major role in systems of care. The role of the state in relation to the community should be to share in providing resources for the system, to establish standards for communities to meet in developing services, to monitor and evaluate the performance of communities, to establish policies and procedures to facilitate effective service delivery, and to provide consultation and technical assistance to help communities. States may also provide certain limited services that are best provided at a regional or state level, either because they are extremely specialized or deal with problems too low in prevalence to support community level efforts. Overall, the role of the state should be to promote the development of strong and effective community-based systems of services.

Within an overall framework of community-based system management of the system of care, there are three basic approaches that can be taken. These approaches include management by a consolidated agency, management by a lead agency, or management by multiple agencies through formal agreements. Each approach is described within the monograph.

Case management plays a critical role in all three system management approaches. Case managers are the "glue" which holds the system together, assuring continuity of services for the child and family. Whether a consolidated agency, lead agency or multiagency management model is used, case managers see to it that the various service components are coordinated and that service needs are assessed and reassessed over time.

Some states and communities have been experimenting with case review committees as an additional management structure (Friedman, 1985). Such committees are used to make or review decisions about appropriate treatment or placement for youngsters in order to insure that the rights of children are protected and that decisions are in the child's best interests.

Several points with respect to system management appear to be important, although they have not yet been empirically tested. It seems essential that, whatever management approach is selected, it should be community-based. Trying to manage a direct service system for youngsters in communities across a state from a state office is cumbersome and inefficient. Further, centralized state level management does not create a sense of commitment in communities for accepting responsibility for serving their children.

It also seems clear, and is a consistent theme of this monograph, that whatever approach is taken must involve the close cooperation of agencies including the mental health, health, social service, juvenile justice agencies and the school system. Such cooperation is needed both for developing and implementing the component parts of the system and for management of the overall system.

Finally, there are increasing indications that case managers are a key component of any attempt to make a system truly responsive to the needs of the individuals it is designed to serve. For a system to be effectively operated, there should be case managers who can pull services together from a variety of sources to meet the needs of individual clients.

STRATEGIES FOR DEVELOPING SYSTEMS OF CARE

Conceptualizing a system of care model is only a preliminary step in the system improvement process. The real challenge for states and communities is to transform their system of care plans into reality. The monograph outlines a number of specific strategies and approaches that might be used to translate plans into functioning networks of services for severely emotionally disturbed children and their families.

System change strategies are defined broadly as planned actions that the mental health agency can take, in collaboration with other appropriate organizations and groups, to promote the development of systems of care for severely emotionally disturbed children and youth (Stroul, 1985).

Each state or community involved in a system development initiative will select system change strategies that are most appropriate for its particular environment and circumstances. Nevertheless, the experience of other system change programs suggests the types of strategies which are most likely to have a broad impact. These system change activities fall within six major areas including:

- Planning and needs assessment,
- Modifying the mental health system,
- Interagency collaboration,
- Technical assistance and training,
- Constituency building, and
- Local system development.

It should be noted that these categories represent not alternative strategies, but rather complementary strategies. In order to develop effective systems of care, states and communities should be selecting and implementing strategies from each of these categories, varying the emphases, strategy types and sequencing to conform with the particular environment.

Within each category, there are innumerable strategies that states or communities may select. A discussion of the strategies within each broad area is included in the monograph.

SYSTEM ASSESSMENT

This monograph has been prepared to assist states and communities to improve services for severely emotionally disturbed children and adolescents. In general, despite significant deficiencies in the present service systems in many states, there is much to be encouraged about. There has been increased attention paid to the needs of emotionally disturbed children and their families. In particular, there is growing recognition that effective service systems require a range of services and close interagency collaboration. Important progress is being made in developing new service components and in providing case management services to link the various services. Additionally, there is an expanding knowledge base about effective community-based service options, system management and strategies for producing system change.

The monograph concludes by presenting a series of questions to assess systems of care on a statewide or community basis. The assessment questions address the characteristics of an effective system with respect to such areas as the development of a model, planning and decision making processes and interagency relationships. The questions are by no means exhaustive; many additional questions and characteristics may be relevant to assessing systems of care.

The assessment questions are followed by sample worksheets for assessing the status of the development of the various system of care components. The assessment questions and worksheets are presented to summarize the information presented in the monograph and to provide readers with a framework for evaluating the status of the system in their state and community.

The monograph is intended to provide states and communities with a conceptual model for a system of care for severely emotionally disturbed children and youth. The model can be used as a guide in planning and policymaking, and provides a framework for assessing present services and planning improvements. The model can be conceptualized as a blueprint for a system of care which establishes directions and goals.

This model should not be seen as the only way to conceptualize systems of care. States and communities may revise and adapt the model to conform with their needs, environments and service systems, or they may develop a distinctly different system of care configuration. The model must also be regarded as flexible, with room for additions and revisions as experience and changing circumstances dictate.

Most important is the acknowledgement that conceptualizing a system of care represents only a **preliminary step** in the service system improvement process. Development of a system of care model is a planning task which must be followed by implementation activities including necessary state level arrangements and local program development efforts. While designing a system of care is an essential and challenging task, the real challenge for states and communities is to transform their system of care plans into reality.

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I. INTRODUCTION

In her book Unclaimed Children, Knitzer (1982) reported that two-thirds of all severely emotionally disturbed children and youth do not receive the services they need. Many others receive inappropriate, often excessively restrictive care. Recently, there has been increasing activity to improve services for severely emotionally disturbed children and adolescents. The National Institute of Mental Health (NIMH) launched the Child and Adolescent Service System Program (CASSP) to assist states and communities to develop comprehensive, community-based systems of care, and coalitions of policymakers, providers, parents and advocates are being forged to promote the development of such systems of care.

This monograph explores the development of comprehensive systems of care for severely emotionally disturbed children and adolescents. The preparation of the monograph was sponsored by CASSP, and the document represents the final product of a collaborative process undertaken by the CASSP Technical Assistance Center at Georgetown University and the Florida Research and Training Center for Improved Services for Seriously Emotionally Disturbed Children at the Florida Mental Health Institute.

The monograph is intended as a technical assistance tool for states and communities interested in improving services for emotionally disturbed children, and as a review of the state of the art for developing systems of care. A generic model of a system of care is presented along with principles for service delivery and alternative system management approaches. This model offers a conceptual framework to provide direction to policymakers, planners and providers. It is expected that states and communities will modify and adapt the model to their particular environments, and will establish priorities for system development in accordance with their needs. This introductory chapter briefly documents the need for systems of care, defines system of care and reviews the background and purposes of the monograph.

THE NEED FOR SYSTEMS OF CARE

In 1969, the Joint Commission on Mental Health of Children published a report entitled Crisis in Child Mental Health (1969). Since that time, there has been growing recognition of the serious unmet needs of children and adolescents with mental health problems. It has been repeatedly documented that a large proportion of emotionally disturbed children and adolescents do not receive adequate, comprehensive care. Despite some attempts to address this problem, there continues to be a "crisis" in child mental health.

The Joint Commission found that millions of children and youth were not receiving needed mental health services. Many of the children that were served received inappropriate, unnecessarily restrictive care, often in state mental hospitals. The President's Commission on Mental Health (1978) echoed the Joint Commission's conclusions, finding that few communities provided the volume or continuum of programs necessary to meet children's mental health needs. Both Commissions recommended that an integrated network of services be developed in communities to meet the needs of severely emotionally disturbed children and youth.

Knitzer (1982) asserted that the needs of severely emotionally disturbed children have remained largely unaddressed. She reported that two-thirds of this group are not getting the services they need, and that many others receive inappropriate or excessively restrictive care. She considers these children to be "unclaimed" by the public agencies with responsibility to serve them. Knitzer also noted the lack of an organized planning process for children in most states.

These reports and others have made it apparent that the range of mental health and other services needed by severely emotionally disturbed children and adolescents is frequently unavailable. Many children are institutionalized when less restrictive, community-based services would be more effective. Additionally, there have been few attempts to get mental health, child welfare, juvenile justice and education agencies to work together on behalf of disturbed children and youth. This has left children and youth with serious and complex problems to receive services in an uncoordinated and piecemeal fashion, if at all.

Currently, there is broad agreement about the critical need to improve both the range and coordination of services delivered to severely emotionally disturbed children and their families. The development of comprehensive, coordinated "systems of care" for children and youth has become a national goal.

Collaboration among Federal and state governments, along with an array of national organizations, has led to a new national initiative to address this goal -- the Child and Adolescent Service System Program (CASSP). CASSP was launched by NIMH in 1984, and is designed to promote the development of comprehensive, coordinated, community-based systems of care for severely emotionally disturbed children and youth. Through CASSP, financial assistance in the form of grants is provided to states. The financial assistance provides initial resources for states to implement a system improvement process. This system improvement process involves activities occurring at the state level that are directed at making a variety of administrative, legislative, budgetary and programmatic arrangements which are necessary to develop systems of care. Additionally, states assist in community level activities designed to develop systems of care for the target population.

Interest in the development of systems of care for severely emotionally disturbed children is not limited to the CASSP-funded states. A number of unfunded states are considering or undertaking system improvement initiatives, and many communities are exploring strategies for improving service delivery to this group. CASSP provides technical assistance to both funded and unfunded states in order to facilitate their efforts on behalf of severely emotionally disturbed children.

This monograph represents one of many technical assistance activities and products sponsored by CASSP. It has been developed in response to numerous requests from the field for guidance in planning and developing systems of care for emotionally disturbed children. It is a critical document in that it addresses CASSP's ultimate goal of insuring the availability of comprehensive, coordinated systems of care for severely emotionally disturbed children and youth in communities. This monograph describes how these systems of care might look and how they might be organized.

DEFINITION OF SYSTEM OF CARE

The term "continuum of care" has been used extensively in the field to describe the range of services needed by severely emotionally disturbed children and adolescents. In fact, much of the published literature and many of the materials produced by states use this term. Throughout this document, the term "system of care" is employed. Before proceeding to describe the system itself, definitions of these terms are required, along with the rationale for using the latter term.

"Continuum of care" generally connotes a range of services or program components at varying levels of intensity. These are the actual program elements and services needed by children and youth. "System of care" has a broader connotation. It not only includes the program and service components, but also encompasses mechanisms, arrangements, structures or processes to insure that the services are provided in a coordinated, cohesive manner. Thus, the system of care is greater than the continuum, containing the components **and** provisions for service coordination and integration.

Additionally, the term "system of care" is used to emphasize the multiple needs of emotionally disturbed children and the importance of establishing effective linkages across child-caring agencies and systems. It is recognized that severely emotionally disturbed children require a variety of services which cut across agency boundaries. Mental health services are, of course, of primary importance, and different types and levels of mental health interventions must be included within the system of care. These mental health services may be provided by one agency or by multiple agencies and programs within a community.

However, the mental health services are dependent for their effectiveness upon the contributions of educational, health, social, vocational and other services. All of these services and agencies must be blended together into an effective **system** in order to avoid fragmentation. Such multiagency systems are essential to ensure that emotionally disturbed children can receive multiple services in a coordinated manner, and that they can easily move among components within the system as their needs change.

A system of care, therefore, is defined as follows:

> **A system of care is a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of severely emotionally disturbed children and adolescents.**

This monograph not only describes the components or services that comprise the system of care, but outlines alternative approaches for "systematizing" the components into a coordinated network.

PURPOSES OF THE MONOGRAPH

As noted, technical assistance is a major priority for CASSP. The CASSP Technical Assistance Center at Georgetown University was established by NIMH to plan and coordinate all of the components of the CASSP technical assistance program, and to conduct a wide range of technical assistance activities. Additionally, NIMH with the National Institute of Handicapped Research funds two research and training centers which focus on severely emotionally disturbed children and youth, one at the Florida Mental Health Institute and one at Portland State University.

The CASSP Technical Assistance Center has conducted several assessment activities in an effort to ensure that technical assistance is responsive to the needs of the field. In all assessments, the area of "system of care" emerged as a priority area of need across states (Stroul, 1985a).

In order to assist states in this area, a two-phase process was initiated by the CASSP Technical Assistance Center in collaboration with the Florida Research and Training Center. The first phase involved soliciting and compiling materials related to systems of care from states which have made progress in this area. Fifteen states contributed their versions of a system of care for severely emotionally disturbed children. These materials were packaged and distributed to all states and territories to provide a sampling of state system of care models (Stroul, 1985b).

Phase two of this process has involved building upon the compilation of materials to develop generic guidelines for systems of care for severely emotionally disturbed children and adolescents. Recommendations and input from the Advisory Committee to the CASSP Technical Assistance Center were used to develop guidelines for system of care components, guiding principles and management approaches. This monograph is the final product of the system of care project, presenting the model developed in the second phase.

The monograph is intended to provide states and communities with a conceptual model for a system of care for severely emotionally disturbed children and youth. The model can be used as a guide in planning and policymaking and provides a framework for assessing present services and planning improvements. The model can be conceptualized as a blueprint for a system of care which establishes directions and goals.

This model should not be seen as the only way to conceptualize systems of care. States and communities may revise and adapt the model to conform with their needs, environments and service systems, or they may develop a distinctly different system of care configuration. The model must also be regarded as flexible, with room for additions and revisions as experience and changing circumstances dictate.

Most important is the acknowledgement that conceptualizing a system of care represents only a **preliminary step** in the service system improvement process. Development of a system of care model is a planning task which must be followed by implementation activities including necessary state level arrangements and local program development efforts. While designing a system of care is an essential and challenging task, the real challenge for states and communities is to transform their system of care plans into reality.

Prior to describing the actual system of care, Chapter II presents essential background information. First, the target population for which the system of care is intended is described. The chapter also reviews the status of system of care development across the nation, noting the major gaps in both availability and coordination of services.

Chapter III of this monograph presents guiding principles for systems of care. The principles address issues related to the nature and quality of the services provided to severely emotionally disturbed children and youth. They also reflect a set of core values or basic beliefs that services must be community-based and provided in a manner that respects the wishes, needs and goals of the child and family.

Chapter IV outlines the specific components that might be included in a system of care. The system of care components are organized into seven dimensions, each representing an area of need for the child and family. The service dimensions include mental health, social services, educational, health, vocational, recreational and operational services.

Alternative management approaches to ensure coordination among the multiple child caring agencies and systems are reviewed in Chapter V. Chapter VI presents the strategies and approaches that states and communities may employ to develop systems of care for severely emotionally disturbed children and adolescents. Finally, Chapter VII concludes the monograph with a framework that states and communities may use to assess their status with respect to systems of care.

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II. BACKGROUND FOR THE SYSTEM OF CARE

SEVERELY EMOTIONALLY DISTURBED CHILDREN AND THEIR NEEDS

The Federal CASSP initiative is focused on severely emotionally disturbed youngsters whose problems are so severe as to require the long-term intervention of mental health and other agencies. To assist states and communities in identifying this population, NIMH developed a set of basic parameters for defining the target population. The parameters are as follows (Stroul, 1983):

- The target population should include children and adolescents under 18 years of age. The need for transitional services for youngsters between 18 and 21 is recognized, but this should not be the primary focus of the system of care.
- The target population should include children whose emotional problems are disabling based upon social functioning criteria. Level of functioning is a critical variable for children and adolescents, determining the nature and level of care that is appropriate. Degree of disability or level of functioning in family, school and community contexts is often more meaningful than mental health diagnosis in planning and delivering services.
- Children and adolescents included in the target population should have a multiagency need. Severely emotionally disturbed youngsters require a range of services which necessitates the involvement of multiple agencies including mental health, health, education, child welfare, juvenile justice, and others.
- Children and adolescents included in the target population should have a defined mental health problem which is diagnosable under DSM-III or another classification system used by the state.
- Children and adolescents included in the target population should have mental or emotional disturbance of a long-term nature. Disability of at least one year duration, or substantial risk of this, may be considered long-term.

As these parameters indicate, the designation of "severe emotional disturbance" among children should be primarily based on functional disabilities which are of significant severity and duration, and on the need for a broad range of services. This set of general criteria is designed to guide the system building efforts of states, while allowing states the flexibility to develop more specific definitions. Several states already have such definitions.

For example, South Carolina indicates that for a child to be considered seriously emotionally disturbed, the child's behavior must exhibit one or more of the following characteristics (Stroul, 1985a):

- The behaviors shall have occurred with sufficient frequency to be considered a pattern of response or to be so intense that the consequences led to severe measures of control by the environment (seclusion, restraints, hospitalization, chemical intervention, etc.)
- The behaviors, although possibly provoked, are judged to be extreme or out of proportion to the provocation or an inappropriate age reaction.

- The behaviors have been judged sufficiently disruptive to lead to exclusion from school, home, therapeutic or recreational settings.

- The behaviors shall be sufficiently intense or severe to be considered seriously detrimental to the child's growth, development or welfare or to the safety or welfare of others.

The state of Washington distinguishes between the descriptive categories of acute dysfunctional, prolonged dysfunctional, disturbed functioning, vulnerable and independent. The category of prolonged dysfunctional requires that a disorder has continued for more than one year, that treatment is likely to continue for at least another year, and that the disorder has resulted in substantial functional limitation in at least two major life activities (Stroul, 1985a).

Multiple categories are also used by the states of Kansas and Michigan. Kansas uses five categories of "mentally ill children and adolescents," and recommends these categories as a substitute for conventional classification systems: children and adolescents with psychosis; children and adolescents with multiple handicaps; children and adolescents with conduct disorders; children and adolescents with anxiety/affective disorders; and children and adolescents at risk of functional disability (Stroul, 1985b). Michigan uses the three broad categories of normal, at risk and dysfunctional (Stroul, 1985a).

In addition to the variety of definitions, there are also a number of different "labels" for this group of children. As Behar (1984) points out, "The definitions of the targeted child population continue to be blurred. The terminology shifts easily from mentally ill to emotionally disturbed to behaviorally disturbed to troubled children to children in trouble. In truth, many of the children have behavioral problems, learning problems and family problems, and frequently have been in legal trouble as well. Most of the children to be served do not neatly divide themselves in the way administrative agencies have been created."

The inconsistency in definitions and labels for this group of youngsters has attracted considerable professional attention. This is unfortunate because the definitional differences often detract from, rather than contribute to, the more important question of identifying needed services and building comprehensive systems of care. The key need is for states to use the broad set of criteria for severely emotionally disturbed children that is provided by CASSP to more specifically define their own target population, and to then move to the task of improving services.

The prevalence of severe emotional disturbance among children and youth is difficult to determine. The primary reasons for this are the lack of agreement about the definition of "severe emotional disturbance," the difficulty in measuring the socio-emotional disturbances, and the great cost and practical obstacles in conducting epidemiological research in children's mental health.

The Joint Commission on the Mental Health of Children (1969) estimated that .6 percent of children are psychotic, an additional two to three percent have other severe emotional disorders and another eight to 10 percent have other types of emotional problems that may require treatment. The President's Commission on Mental Health (1978) did not differentiate between types or degree of emotional disturbance, but rather estimated that between five and 15 percent of children require mental health services.

Based on a review of a number of epidemiological studies, Gould, Wunsch-Hitzig & Dohrewend (1981) estimated that the prevalence of "clinical maladjustment" among children is at least 11.8 percent. In a recent review of community and national surveys, Links (1983) concluded that the 11.8 percent estimate was conservative. However, he also reported that few definitive conclusions can be drawn because each of the surveys differed in terms of the definitions of the disorders studied, the age groups investigated and the instruments used.

Given the methodological inconsistencies and deficiencies in the research, it is difficult to derive a precise estimate of the prevalence of mental health problems in youngsters. The estimate by Gould et al. (1981) of 11.8 percent appears to be a reasonable, if not somewhat conservative, estimate.

A subset of this group of children showing emotional problems can be considered **severely** emotionally disturbed. From a review of existing prevalence research, Knitzer (1982) concluded that a conservative estimate of serious emotional disturbance in children is five percent or approximately three million youngsters. In the description of CASSP, NIMH (1983) has adopted the same figure. While this figure is not firmly based empirically, it appears to be generally consistent with the research and reasonable as an estimate. It should be kept in mind that this five percent estimate includes only youngsters whose problems are severe and persistent, while the 11.8 percent estimate includes all emotionally disturbed youngsters.

Figure 1 organizes these prevalence estimates along two key dimensions, both of which are included in the CASSP population definition. The first dimension is social impairment, or the extent to which the problem is disabling, handicapping or in some way interferes with the effective functioning of the individual. The second dimension is persistence, or the extent to which the problem continues over time. The matrix shows that some problems are short in duration and interfere with functioning to only a mild extent (cell 1). Other problems may be persistent, but still interfere with functioning only mildly (cell 2).

In contrast, there are problems that are of short duration, but involve a significant impairment in functioning (cell 3). Youngsters in this category are often considered to be "acutely" disturbed or in crisis. The fourth cell represents those problems that are both persistent and severe in the extent to which they impair functioning. It is in this category that severely emotionally disturbed youngsters fall.

While differences around definition and prevalence may persist, there is greater consensus about the needs of severely emotionally disturbed children. These children require a range of mental health services which are age appropriate and at varying levels of intensity. However, mental health services alone are not enough. Emotionally disturbed children almost universally manifest problems in many spheres including home, school and community. As a result, they require the intervention of other agencies and systems to provide special education, child welfare, health, vocational and, often, juvenile justice services.

Thus, the needs of severely emotionally disturbed children and youth cannot be met by the mental health system in isolation. A comprehensive array of mental health and other services are needed to meet their needs. The conclusions of nearly all commissions and experts converge in recommending a multiagency, multidisciplinary system of services for emotionally disturbed children and their families. A comprehensive, coordinated network of services is essential to provide for the multiple needs and problems of this population.

FIGURE 1

PREVALENCE ESTIMATES

		PERSISTENCE	
		SHORT - TERM	LONG - TERM
SEVERITY OF HANDICAP	MILD	1	2
	SEVERE	3	4

PREVALENCE ESTIMATES

PREVALENCE (CELLS 1 - 4) = 11.8%

SED PREVALENCE (CELL 4) = 5%

STATUS OF SYSTEM OF CARE DEVELOPMENT

Although comprehensive systems of care for emotionally disturbed children have been recommended for some time, progress in developing such systems has been slow. As mentioned previously, Knitzer (1982) estimated that two-thirds of the seriously disturbed children in this country are not getting the services they need. This estimate was based on a combination of data on the number of emotionally disturbed children served by the public schools and the number served through traditional mental health agencies. After reviewing the research on treatment effectiveness for children and adolescents, Friedman (1984) concluded that, "The preponderance of evidence clearly supports the premise that not only are severely emotionally disturbed children underserved, but they are also frequently inappropriately served."

This is particularly true because of the multiple needs of severely emotionally disturbed children. As noted, their problems often require the attention of education, social service, retardation, delinquency, physical health and vocational agencies as well as mental health. Given the multiple problems and needs, a comprehensive approach to treatment requires an integrated combination of services and close collaborative efforts among different agencies.

Knitzer's study (1982) revealed that state efforts to develop comprehensive systems of care were lacking. Few states were addressing the needs of severely emotionally disturbed children in a systematic way, and there were almost no attempts to get state mental health, child welfare, juvenile justice and education departments to work together on behalf of disturbed children and adolescents.

At present, there are serious gaps both in terms of the mental health services that are available to children and their families and the other essential services. Where such gaps in actual service do not exist, the lack of coordination between agencies seriously limits the effectiveness of individual service components. The consequence of these system deficiencies is that treatment is often inadequate and fragmented.

The situation is complicated by an overreliance on more expensive and more restrictive services than are actually needed. Behar (1984) reports a strong tendency to remove children from their families and natural environments with the belief that effective treatment can only be accomplished in a residential setting. Knitzer (1982) identified efforts to increase residential care in almost half of the states, while nonresidential services remained either nonexistent or rudimentary. Thus, residential services appear to be overutilized, although recent experience indicates that intensive services in the home and school may reduce the need for residential care (Friedman and Street, 1985). When residential care is indicated, less restrictive, community-based alternatives such as therapeutic foster care are often neglected in favor of institutionally-based services.

Consistent with the overuse of residential services, is the general lack of emphasis within the service system on the family. Efforts to support emotionally disturbed children in the context of their families are often superficial, and a strong commitment to preserve the family when possible is often lacking. Frequently, parents are not acknowledged as the primary care-givers for emotionally disturbed children, and are not included as partners in planning and decision making with regard to their children.

While these problems remain, there are indications of progress in services for severely emotionally disturbed children. The need for comprehensive, community-based systems of service that incorporate a wide range of different services is receiving more and more recognition. When Knitzer (1982) conducted her research on children's mental health services, she found that only seven state mental health departments had taken even limited steps to create systems of care for children. A more recent study by Isaacs (1983, 1984) found that a number of states have identified children's mental health as one of their top mental health priorities. Additionally, the first call for CASSP proposals by NIMH brought responses from 44 states and territories, indicating considerable interest in strengthening services for severely emotionally disturbed children and youth.

Isaacs' study resulted in a report describing the activities of five states to improve service delivery systems for severely emotionally disturbed children (Isaacs, 1983). These states were selected based on their demonstrated commitment and efforts to develop systems of care for the target population. The states were Florida, Maine, Michigan, North Carolina and South Carolina.

North Carolina's "Willie M." program was initiated as a result of a 1979 class action suit. The program has involved the development of systems of services for severely emotionally disturbed children and adolescents throughout the state. A needs assessment was conducted along with an inventory of existing services, resulting in a plan for the development of needed services. System development has involved coordination of area programs within larger geographic zones. A continuum of mental health, education and other support services was delineated, and by 1983 all 41 area mental health programs had received grants to develop these specified services. Critical aspects of the North Carolina system are strong case management and system management which ensure both coordination of services and continuity of care.

In 1980, Florida developed a model for a continuum of care with nine basic services for seriously emotionally disturbed children, and has been systematically working to implement the services. An additional impetus to Florida's effort resulted from a bill passed by the legislature in 1981 which established a multiagency network for severely emotionally disturbed students (SEDNET). The legislation specifies that the network should develop and provide education, mental health treatment and, when necessary, residential services for these children. Pilot projects have been developed in several regions to test the approach.

Maine's Interdepartmental Committee was established in 1978. The Committee's efforts have been instrumental in developing and coordinating services for emotionally handicapped children. The major goal of the initiative is to develop coordinated programs in the least restrictive, most appropriate settings possible. Needed services have been developed, particularly day treatment and home-based services. Maine has been especially successful in the development of cooperative interagency efforts at the state and community levels.

Michigan appointed a study group in 1982 to make recommendations regarding the management and delivery of public mental health services to children and youth. As a result, an elaborate continuum of services for children and their families was defined, and efforts have been directed at working with local community mental health boards to assume responsibility for developing and coordinating systems of care.

A South Carolina task force published its report in 1983 offering alternative models for the development of a continuum of care for emotionally disturbed children and youth. Based on this report, the legislature passed a bill establishing the Continuum of Care Policy Council and mandating statewide development of services. A demonstration project was funded initially, with broader implementation efforts to follow. A number of other exemplary efforts in interagency cooperation, particularly between mental health and education, have also been identified (Street & Friedman, 1984).

While the states described by Isaacs have been the forerunners, many other states are now initiating system development activities. Nearly half of the states in the nation are now involved in the CASSP initiative. Both funded and unfunded states are participating in technical assistance activities related to system of care development such as national and regional conferences. It seems clear that interest in developing comprehensive systems of care has increased markedly.

There also seems to be a growing consensus that the knowledge base for effective services for severely emotionally disturbed children has grown rapidly. Friedman (1984) reviewed progress in the field and concluded that, "Recent developments both with regard to integrated systems of service and creative new programs of service offer considerable promise." The challenge now is to translate the increased knowledge into action -- to actually put into practice the knowledge that is available to serve emotionally disturbed children and youth. This document, and the entire CASSP initiative, is directed precisely toward this much needed translation of knowledge into action.

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III. PRINCIPLES FOR THE SYSTEM OF CARE

The system of care for severely emotionally disturbed children and adolescents represents more than a network of service components. Rather, the system of care represents a **philosophy** about the way in which services should be delivered to children and their families. The actual components and organizational configuration of the system of care may differ from state to state and from community to community. Despite such differences, the system of care should be guided by a set of basic values and operational philosophies. It is critical that these values be clearly articulated so that they may be used to guide the character and quality of the system of care.

Not surprisingly, there is general agreement in the field and in the literature as to the values and philosophy which should be embodied in the system of care for severely emotionally disturbed youth. The recommendations for guiding principles cut across professional and agency boundaries with striking consistency. Experts, associations, states, task forces and advisory groups have, by and large, arrived at similar conclusions about the optimal nature of the system of care. With input and consultation from the field, two core values and a set of 10 principles have been developed to provide a philosophical framework for the system of care model.

The two core values are central to the system of care and its operation. The first value is that the system of care must be driven by the needs of the child and his or her family. In other words, the system of care must be **child-centered**, with the needs of the child and family dictating the types and mix of services provided. This child-centered focus is seen as a commitment to adapt services to the child and family, rather than expecting children and families to conform to pre-existing service configurations. It is also seen as a commitment to providing services in an environment and a manner that enhances the personal dignity of children and families, respects their wishes and individual goals, and maximizes opportunities for involvement and self-determination in the planning and delivery of services.

Implicit in this value is a commitment to serving the child in the context of the family. In most cases, parents are the primary care-givers for severely emotionally disturbed children, and the system of care should support and assist parents in this role as well as involve parents in all decisions regarding service delivery. The system of care should also have a strong and explicit commitment to preserve the integrity of the family unit whenever possible. In many cases, intensive services involving the child and family can minimize the need for residential treatment. Thus, a child-centered system of care is also a family-focused system of care.

The second core value holds that the system of care for emotionally disturbed children should be **community-based**. Historically, services for this population have been limited to state hospitals, training schools and other restrictive institutional facilities. There has been increasing interest and progress in serving such children in community-based programs which provide less restrictive, more normative environments. The system of care embraces the philosophy of a community-based network of services for emotionally disturbed youth and families. While "institutional" care may be indicated for certain children at various points in time, in many cases appropriate services can be provided in other, less restrictive settings within or close to the child's home community.

The notion of a community-based system of care extends to the control and management of the system of care as well as the actual services. Decisions about the

TABLE 1

CORE VALUES FOR THE SYSTEM OF CARE

1. The system of care should be child-centered, with the needs of the child and family dictating the types and mix of services provided.

2. The system of care should be community-based, with the locus of services as well as management and decision-making responsibility resting at the community level.

GUIDING PRINCIPLES FOR THE SYSTEM OF CARE

1. Emotionally disturbed children should have access to a comprehensive array of services that address the child's physical, emotional, social and educational needs.

2. Emotionally disturbed children should receive individualized services in accordance with the unique needs and potentials of each child, and guided by an individualized service plan.

3. Emotionally disturbed children should receive services within the least restrictive, most normative environment that is clinically appropriate.

4. The families and surrogate families of emotionally disturbed children should be full participants in all aspects of the planning and delivery of services.

5. Emotionally disturbed children should receive services that are integrated, with linkages between child-caring agencies and programs and mechanisms for planning, developing and coordinating services.

6. Emotionally disturbed children should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner, and that they can move through the system of services in accordance with their changing needs.

7. Early identification and intervention for children with emotional problems should be promoted by the system of care in order to enhance the likelihood of positive outcomes.

8. Emotionally disturbed children should be ensured smooth transitions to the adult service system as they reach maturity.

9. The rights of emotionally disturbed children should be protected, and effective advocacy efforts for emotionally disturbed children and youth should be promoted.

10. Emotionally disturbed children should receive services without regard to race, religion, national origin, sex, physical disability or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.

mix of services to be offered, service coordination mechanisms, placement and the use of resources should be made at the community level in cooperation with the state level. Such flexibility and decision making authority encourages communities to accept responsibility for serving their youngsters.

In addition to these two fundamental values for the system of care, 10 principles have been identified which enunciate other basic beliefs about the optimal nature of the system of care. The values and principles are displayed on Table 1, and each principle is briefly discussed below.

1. **Emotionally disturbed children should have access to a comprehensive array of services that address the child's physical, emotional, social and educational needs.**

It is axiomatic that children and their families should have access to comprehensive services across physical, emotional, social and educational domains. The Joint Commission on the Mental Health of Children (1969), the President's Commission on Mental Health (1978) and innumerable child mental health experts and advocates have stressed the conviction that a complete and comprehensive network of services is necessary to meet the multidimensional needs of children and families.

While emotionally disturbed children require specialized mental health services, these services are insufficient to promote proper growth and development. Mental health services can be effective only within the context of a larger child-caring network which is responsible for meeting the child's health, educational, recreational, family support and vocational needs. Thus, the scope and array of services included in the system of care must be sufficiently broad to account for the diverse needs of the developing child. As noted by Lourie and Katz-Leavy (1986), proper care relies on proper balance and integration of services in the various domains.

2. **Emotionally disturbed children should receive individualized services in accordance with the unique needs and potentials of each child, and guided by an individualized service plan.**

Each child and family served by the system of care has unique and changing needs. These needs are related to differences in age, developmental stage, level of functioning or degree of impairment, and special needs resulting from physical handicaps, racial or ethnic background or other factors. Thus, the types, mix and intensity of services must be determined for each child and family. Again, one of the basic philosophical tenets of the system of care is that children should not be expected to conform to the service system, but that services should be designed and configured to fit the child's needs.

In order to individualize services, a comprehensive diagnostic and assessment process must be an integral part of the delivery of services. The assessment process offers the opportunity to consider the child's problems and strengths, level of functioning, age and developmental stage, and any special needs that bear upon service delivery. The assessment process should be "ecological," considering the child in the context of the family, school and other relevant environments. It should be noted that the assessment process does not necessarily precede treatment or occur apart from service delivery. Particularly for children and families in crisis, or where resistance is high, it may be more important to first engage the child and family in the therapeutic process, deferring a thorough assessment or gathering information more informally as services are provided.

The culmination of the assessment process should be an individualized service plan which identifies problems, establishes goals and specifies appropriate interventions. The individualized service plan should address the child's needs across all the major system of care dimensions -- mental health, social, educational, health, vocational, recreational and operational services.

The individualized service plan should be developed with the full participation of the child, family, providers and significant others. Children and families should retain the greatest possible degree of control over their own lives, participating in the setting of their own treatment goals and in the planning and evaluation of interventions to reach those goals. Additionally, goals and expectations developed in the assessment and service planning process should be realistic and based upon a thorough knowledge and acceptance of the child and family. Unrealistic goals may doom the interventions to failure, and cause needless frustration for the child and family.

Service goals should be regularly reassessed and revised based on the dynamic nature of the strengths, weaknesses and needs of the child and family. An ideal system of care allows the child opportunities to progress and to move to less restrictive settings as well as to use more intensive forms of services when indicated.

3. **Emotionally disturbed children should receive services within the least restrictive, most normative environment that is clinically appropriate.**

Children and adolescents should be served in as normal an environment as possible. Preferred interventions are those that provide the needed services and at the same time are minimally intrusive in the normal day to day routine of the child and family. An implicit goal of the system of care is to maintain as many children as possible in their own homes by providing a full range of family-focused and community-based services and supports. In too many cases, children are removed from their homes or placed in environments that are more restrictive than they actually need. While out-of-home or protective placements may be indicated some of the time, frequently they are used because less restrictive, community-based alternatives are not available. Accumulating evidence indicates that when a comprehensive system of care is available, many severely emotionally disturbed children can be maintained within their own homes and communities (Behar, 1985, 1986; Friedman & Street, 1985).

It is also evident that the needs of a small percentage of emotionally disturbed youth cannot always be met in the less restrictive settings. In these cases, even intensive nonresidential services may not meet the therapeutic needs of the child and family, and it may not be in the child's best interest to remain with the family. Residential services should be employed **only** when more normative, nonresidential options are not effective. In these situations, residential services should be provided in the least restrictive setting possible, with the goal of rapid reintegration into the family or achievement of a stable, permanent placement.

Within the residential arena, there are a range of more normative options which attempt to approximate the child's natural environment. For example, therapeutic foster homes and family style group homes create a family-type atmosphere and allow children to attend public schools and to remain involved in community activities. According to Friedman, these services have more potential for helping youngsters to realize the goal of returning to their own family and school than do residential services which cut youngsters off from normalized family and educational environments (Friedman, 1983).

By the same token, residential services, when indicated, should be located as close as possible to the child's home in order to cause the least disruption of the child's links to family, friends, agencies, school and community. Services located close to home maximize the possibility of family involvement in the treatment process, and are more likely to prepare the child for successful reintegration into the natural environment.

It must be acknowledged that there may be situations in which treatment in institutional settings is appropriate. In these cases, a child may need highly specialized services which are not reproducible in a community setting. Behar reports, however, that in North Carolina less than seven percent of the most difficult target population (those certified as belonging to the "Willie M." class) is in secure treatment settings including public and private hospitals and secure residential treatment centers, and that these placements are considered appropriate to the needs of the youngsters. The North Carolina data suggest that the vast majority of severely emotionally disturbed youth can be served in less restrictive, community-based settings given the appropriate continuum of services and supports (Behar, 1985, 1986).

4. **The families and surrogate families of emotionally disturbed children should be full participants in all aspects of the planning and delivery of services.**

The system of care for emotionally disturbed children should promote and encourage the involvement of families, be they natural or surrogate families. Parents and families should not be passive participants, but should be actively consulted and involved in all decision making about the child and services. Thus, the system of care should have a strong family orientation.

The President's Commission on Mental Health (1978) concluded that "Mental health services for children must also be delivered within a system of care that insofar as possible promotes and maintains a continuing relationship between child and family. . .We recommend that parents be partners with providers in determining a plan of treatment for every severely disturbed or handicapped child." Similarly, Lourie and Katz-Leavy (1986) noted that parents are the most important resource for the child, and must be given the necessary support to fulfill that role.

In order to establish parents as partners in the system of care, they should be involved in all phases of service delivery including assessment, development of the individualized service plan, service provision, service coordination and evaluation of progress. In addition, an array of services and supports should be offered to parents and families to enhance their coping skills and their ability to care for their children effectively. These services include parent support, parent education, counseling, respite services, home aid services and others. Recently, a number of innovative models have been developed for providing these services and supports to families. There is increasing evidence that when adequate family support is available, many families are able to maintain severely emotionally disturbed children at home and avoid placement in residential or institutional settings.

Even when children are in out-of-home placements, the participation and involvement of parents should be encouraged. In fact, family needs are most often neglected when children are in residential settings, either due to distance or other factors. Outreach efforts should be made to reach families and engage them constructively in the service delivery process. By involving and providing supports to families, the opportunities for successful return of the child to the family are maximized.

While family involvement is the goal, no child should be denied services because he or she has no traditional family or the family refuses participation. Where the natural family is not involved, the system of care should engage the surrogate or substitute family in services. Where this is not possible, a strategy appropriate to the youngster's particular situation should be devised.

5. **Emotionally disturbed children should receive services that are integrated, with linkages between child caring agencies and programs and mechanisms for planning, developing and coordinating services.**

While states and communities may be developing more comprehensive services for severely emotionally disturbed children and adolescents, this does not ensure coordination of services or continuity of care. Nor does it ensure that the system will be able to respond to the changing service needs of children and their families. Coordination, continuity and movement within the system are critical for severely emotionally disturbed youth who have multiple needs that cut across agency boundaries. In order to best meet the needs of children and families, **integrated, multiagency networks of services** are needed to blend the services provided by mental health, education, child welfare, health, retardation, juvenile justice and other agencies. In short, the various components must be interwoven into a coherent and effective system.

Service integration should be sought on several levels. Planning, program development, administration, funding, delivery, coordination and evaluation of services are some of the functions that should be shared by the agencies and programs linking together to serve severely emotionally disturbed children and their families. Further, the system should be flexible in decision making and funding to allow the system to respond to changing programmatic needs in the community. For example, a management structure might be created which would provide a mechanism for shifting funds and staff in response to shifts in the needs for particular service components.

6. **Emotionally disturbed children should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner, and that they can move through the system of services in accordance with their changing needs.**

Case management has been called the backbone of the system of care, and is essential to the success of the service system. Case management, therapeutic case advocacy and a variety of similar approaches are intended to ensure that children and families receive the services they need, that services are coordinated, and that services are appropriate to their changing needs over time. Lourie and Katz-Leavy (1986) assert that "Without such a primary service person responsible for the coordination of the treatment plan, it is nearly impossible to assure adequate services and proper placement for an individual severely emotionally disturbed child or adolescent." Clearly, the case management function is critical for the effective operation of the system of care.

The location of the case manager or service coordinator cannot be predetermined. This should be determined by the needs of individual children and families and by the structure and resources of the system of care within a particular community. The role of the case manager, however, has been more clearly articulated, and includes a number of essential functions:

- Coordinating the comprehensive interagency assessment of the child's needs.
- Planning for services to address the needs of the child and family.
- Arranging for needed services.
- Linking the various parts of the child's system including family, agencies, school, and significant others.
- Monitoring the adequacy and appropriateness of services.
- Ensuring continuity of service provision.
- Advocating for the child and family.
- Establishing linkages with the adult service system to facilitate transition.

These functions are essential, unifying factors in service delivery. Behar (1984) contends that case management is "the element of planning and coordinating that has held together the workings of all the agencies concerned with the child, the energizing factor that has propelled the service plan into the reality of service delivery, the case advocacy strength that has sustained a commitment to each child and an optimism about each child's capability to change."

7. **Early identification and intervention for children with emotional problems should be promoted by the system of care in order to enhance the likelihood of positive outcomes.**

Emerging evidence indicates that early identification and intervention can have a significant effect on the course of emotional disorders in children (Friedman, 1984; Cowen, Trost, Lorion, Dorr, Izzo & Isaacson, 1976). Such early intervention can, in some cases, reverse early maladaptive patterns and prevent problems from reaching serious proportions. Thus, early identification and intervention efforts have the potential for a major impact on serious emotional disturbance in children.

One of the goals of the system of care should be to reduce the prevalence and severity of emotional disturbance through effective early identification and intervention. While there is increasing interest in screening and intervention programs to identify and assist high risk children and families, these services are often neglected in favor of much needed services for children who are already demonstrating serious problems. The challenge to the system of care is to achieve an appropriate balance between early identification and intervention services and services designed for youth with severe and persistent problems.

8. **Emotionally disturbed children should be ensured smooth transitions to the adult service system as they reach maturity.**

The transition from the system of care for severely emotionally disturbed children and youth to the adult service system is fraught with problems. Children who "age out" of the system of care become young adults who are often in need of long-term mental health care, vocational services and a range of other support services. However, a number of factors complicate a smooth transition, and make it difficult for these young adults to receive appropriate services.

First, there may be difficulties in accessing the mental health and other needed services from the adult service system. Aging out of the system of care for children generally means moving to an entirely new set of agencies and programs to provide needed services. Identifying, applying and becoming established with the adult agencies may be a complex and cumbersome task. A second complication results from the transition from school to the world of work. Many of these youth have no prevocational or vocational skills and may not be employable. Further, they may not be viewed positively by vocational rehabilitation agencies which look for substantial promise of a successful outcome. They may, therefore, be left with a void without school, job or opportunities to enhance their employability.

Philosophical differences also complicate the transition from the child to the adult service system. While the system of care for children and adolescents is based on a growth-promoting, "habilitative" philosophy, the adult service system is based on the philosophy of disability and rehabilitation. This philosophical difference may present problems for aging out youth and their families, possibly discouraging their use of needed adult services.

Finally, adult agencies may be ill-prepared to serve many of the youth who have been served by the system of care for children. The adult agencies have been developing programs to serve the chronically mentally ill. However, only a small percentage of the aging out youth would fit the definition of chronically mentally ill adults. Many have not met the hospitalization criteria, and many evidence conduct disorders rather than overt psychotic disorders. Their problems often include drug and alcohol usage. The programs offered by the adult mental health and other agencies may be inappropriate to the needs and characteristics of the "youth in transition" population.

Clearly, the system of care for severely emotionally disturbed youth cannot address all the issues related to transition to the adult service system. Nevertheless, the system of care should establish functional linkages with relevant adult agencies. These linkages should be used to ensure continuity of services for individual youth and families as well as to work with the adult system to become responsive to the needs of youth in transition.

9. The rights of emotionally disturbed children should be protected, and effective advocacy efforts for emotionally disturbed children and youth should be promoted.

The system of care should be an advocate for the child. The "child advocacy" function of the system of care should be evident in several areas. First, the system of care should adopt mechanisms to ensure the protection of client rights. Such mechanisms may include statutes, statements of the rights of children, grievance procedures, case review committees and protection and advocacy systems.

Such mechanisms are needed to protect the rights of children in several respects. One basic right of all children is to be treated in the least restrictive, appropriate setting. Safeguards may be necessary to ensure that this right is upheld as well as rights upon admission to hospitals and other facilities, rights of children within facilities, rights related to removal from homes, etc. A complicating factor in protecting the rights of children occurs when the rights of the child and the rights of the parents may be in conflict.

In addition to rights protection, the system of care should actively promote advocacy activities on behalf of emotionally disturbed children and adolescents. Case advocacy is defined as efforts on behalf of an individual child to ensure that the child and his or her family receives appropriate services, benefits or protections. Class advocacy involves efforts to seek improvements in services, benefits or rights on behalf of all severely emotionally disturbed children and youth (Knitzer, 1984). Both case advocacy and class advocacy are vital to the success of the system of care. A strong and vocal network to advocate for the needs of emotionally disturbed children has been notably lacking in the past. Knitzer (1984) recognized that "Current recognition of the need to create systems of care for disturbed children is also a challenge and an opportunity to strengthen the advocacy effort on their behalf."

Currently, efforts to build support for children's mental health issues are increasing. A broad-based constituency of parents, professionals and child advocates is growing, and beginning to provide the much needed voice in support of system of care development. Similar advocacy coalitions are needed at the state and community levels as an integral part of the system of care.

10. **Emotionally disturbed children should receive services without regard to race, religion, national origin, sex, physical disability or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.**

The system of care should uphold a policy of nondiscrimination in the delivery of services. All emotionally disturbed children and families should have access to quality services, including minority children and children with special needs such as physical handicaps. Special efforts and arrangements may be indicated in order to be responsive to the special needs of children and families. Without such efforts, the system of care could not truly be child-centered. The President's Commission on Mental Health (1978) emphasized this principle. "Clearly services should respect ethnic differences and preferences. Quality of services should be independent of the socioeconomic or ethnic groups being served. Services should be adapted to suit the lifestyles, language and expectations of the children and families being served."

The task of developing a comprehensive system of care for severely emotionally disturbed children is both complex and difficult. These principles describe the characteristics of such a system of care and the values on which it is based -- comprehensiveness, individualization, least restrictive setting, family orientation, service integration, case management, early intervention, smooth transitions, rights protection and advocacy, and nondiscrimination.

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IV. COMPONENTS OF THE SYSTEM OF CARE

This chapter presents the framework and components for a system of care for severely emotionally disturbed children. The specific model to be presented represents one approach to a system of care. No single approach has as yet been adequately implemented and tested to be considered the ideal model. The model presented is designed to be a guide, based on the best available empirical data and clinical experience to date. It is offered as a starting point for states and communities as they seek to build their systems, as a baseline from which changes can be made as additional research, experience and innovation dictate.

While individuals may wish to examine the services in their own states and communities in relation to the system presented here, the information is not intended to be used as a checklist. The desired system in a particular community is dependent, in part, upon community characteristics such as population, physical size, proximity to other communities, unique resources and special features of the population. Not every community is expected to have every service in place. The model is not a prescription, but rather should serve as a guide for communities, with the expectation that it will be modified and adapted to meet special conditions and needs.

States and communities are also expected to establish different system development priorities. An approach frequently used involves defining a core or minimal set of services as the first priority for system of care development efforts. When goals in relation to this core set of services are achieved, states and communities may then begin to develop an expanded array of service options.

The system of care model is organized in a framework consisting of seven major dimensions of service, each dimension representing an area of need for children and their families. The framework is graphically presented as Figure 2, and includes the following dimensions:

1. Mental health services

2. Social services

3. Educational services

4. Health services

5. Vocational services

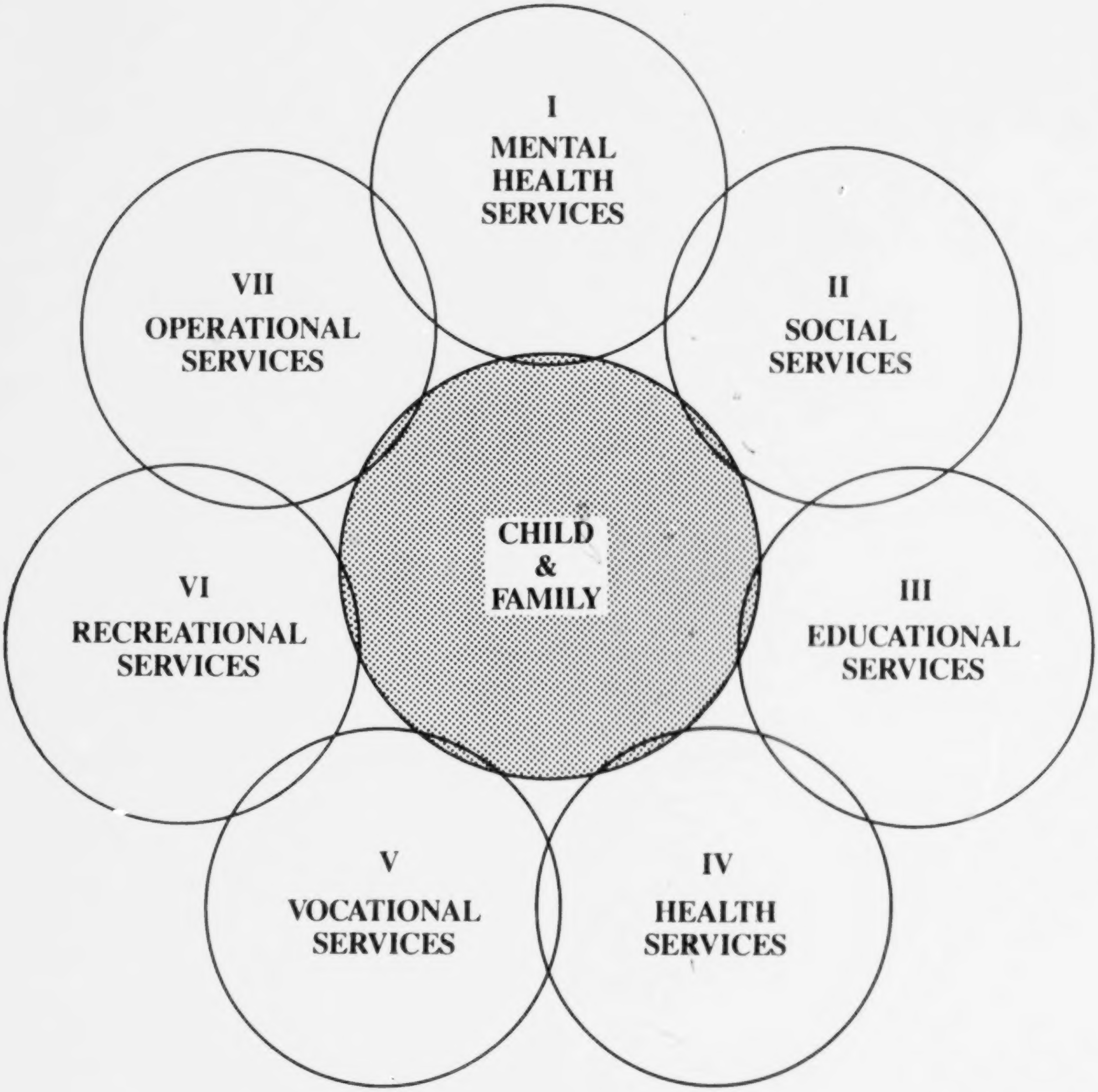
6. Recreational services

7. Operational services

This approach is taken in recognition of the fact that severely emotionally disturbed children have multiple needs that span a variety of services, agencies and systems. A comprehensive and effective system for severely emotionally disturbed children should be based on planning efforts that take into account these multiple needs and involve different agencies. The system of care should also insure that there are close linkages between the various components so that an integrated and complementary set of services can be provided to children and families.

FIGURE 2

SYSTEM OF CARE FRAMEWORK


I
MENTAL
HEALTH
SERVICES
II
SOCIAL
SERVICES
III
EDUCATIONAL
SERVICES
IV
HEALTH
SERVICES
V
VOCATIONAL
SERVICES
VI
RECREATIONAL
SERVICES
VII
OPERATIONAL
SERVICES
CHILD
&
FAMILY

The system of care model is intended to be **function-specific** rather than agency-specific. Each service dimension addresses an area of need for children and families, a set of functions that must be fulfilled in order to provide comprehensive services to meet these needs. The model is **not** intended to specify which type of agency should fulfill any of the particular functions or needs. Certainly, particular agencies typically provide certain of these services in communities. Educational services, for example, are most often provided by school systems, and social services are generally associated with child welfare or social welfare agencies. One might assume that the mental health services should be provided by mental health agencies. This, however, is often not the case.

All of the functions included in the system of care dimensions may be fulfilled by a variety of agencies or practitioners in both the public and private sectors. Therapeutic group care, a component in the mental health dimension, is often fulfilled by juvenile justice agencies and social service agencies as well as by mental health agencies. Day treatment is another mental health function that is frequently fulfilled by the educational agencies, ideally in close collaboration with mental health providers.

While the roles and responsibilities of specific agencies are acknowledged, an effective system of care should be based on child and family needs primarily, rather than on agency features. Many of the services to be described can be, and are, provided by different agencies in different communities.

Furthermore, many of these services are provided not through the efforts of any single agency but through multiagency collaborative efforts. Such collaborations are important not only in identifying needs and planning services but also in developing, funding and operating services. Within this chapter, specific recognition is given to those services which typically involve, or should involve, such collaborative efforts.

It should also be recognized that services are not always provided by agencies. Some functions within the system of care may be fulfilled by families, parent cooperatives or other such arrangements. Respite care is one example of a service that can be provided through the efforts of parent cooperatives. Private sector facilities and practitioners can also play a pivotal role in the system of care, providing a wide range of services within each of the major dimensions.

Juvenile justice agencies play an important role in the system of care. The juvenile justice system provides a wide range of services to children and adolescents who have broken the law. While the juvenile justice system has an interest in helping children and families, its mission is also to meet the needs of the community and society. This mission is accomplished through measures to control troublesome or delinquent behavior (Shore, 1985). Many juvenile offenders can be considered emotionally disturbed, and the juvenile justice system plays a critical role in serving emotionally disturbed juvenile offenders. Juvenile justice agencies provide or collaborate with other agencies to offer many of the system of care components to this subgroup. Among the components frequently provided by juvenile justice agencies are outpatient services, therapeutic foster and group care and residential treatment. The critical role of the juvenile justice system in serving emotionally disturbed juvenile offenders must be acknowledged as well as its special role in the system of care.

An important aspect of the concept of care is the notion that all components of the system are interrelated, and that the effectiveness of any one component is related to the availability and effectiveness of all other components. For example, the same day treatment service may be more effective if embedded in a system that also includes good outpatient, crisis and residential treatment, than if placed in a system where the other services are lacking. Similarly, such a program will be more effective if social, health, and vocational services are also available in the community than if they are absent or of low quality. In a system of care, all of the components are interdependent--not only the components within a service dimension such as mental health, but all of the seven service dimensions that comprise the model.

A critical characteristic of an effective system is an appropriate balance between the components, particularly between the more restrictive and less restrictive services. If such balance is not present, then youngsters and families will not have a full chance to receive less restrictive services before moving to more restrictive services. If, for example, within a community there are no intensive home-based services, only 20 day treatment slots and 50 residential treatment slots, the system is not in balance. Youngsters and families will most likely not have the opportunity to participate in home-based or day treatment services because of their relative unavailability, and the residential components of the system will be overloaded with youngsters, some of whom might have been diverted from residential treatment if there had been more nonresidential services available.

Further, once youngsters are placed in residential treatment in such an unbalanced system, the opportunities for their discharge are reduced because of the scarcity of nonresidential services to provide follow-up care. Thus, an unbalanced system creates an array of problems including overuse of more restrictive services and extended periods of time spent in more restrictive settings.

In this regard, data for Fiscal Year 1983 indicate that of all of the expenditures of state mental health agencies in the country, 67 percent were for residential treatment, only 17 percent for ambulatory care, and the remaining 16 percent were not classified (NASMHPD, 1985). Planners and policymakers must struggle with the issue of how to gradually shift these funding patterns to achieve a more appropriate balance.

At the present time there are no clear, empirically-based guidelines about the appropriate capacity within each component of a system of care. As a consequence, no specific quantitative guidelines are presented in this document. Implicit within a model system of service, however, is the expectation that more youngsters will require the less restrictive services than the more restrictive ones, and that service capacity should, therefore, diminish as one proceeds through the system. In particular, the system capacity in the more intensive of the nonresidential services should exceed the system capacity in the residential service components. As additional research and field experience are accumulated with respect to systems of care for severely emotionally disturbed children, it may become possible to define the optimal ratios of capacities in the different system components.

Within each of the seven service dimensions is a continuum of service components. Each of these dimensions is described below. The major focus, however, is on the continuum of mental health services since these are critical services for all severely emotionally disturbed children. While the mental health dimension is described in some detail, brief descriptions are provided with respect to the other dimensions. These descriptions are intended as introductions to the service dimensions, and not as comprehensive reports on all the services included in the system of care.

Throughout the discussion of the individual services, it should be recalled that these are component parts of an overall system of care. The boundaries between the various dimensions and components are not always clear, and frequently there is overlap among them. While they are described individually, the system of care dimensions and service components cannot be operated in isolation. Only when the services are enmeshed in a coherent, well-coordinated system will the needs of severely emotionally disturbed youngsters and their families be met in an appropriate and effective manner.

DIMENSION 1: MENTAL HEALTH SERVICES

The mental health services of the system of care are listed in Table 2. They are divided into seven nonresidential categories, and seven residential categories. The components often overlap to some degree. For example, the difference between therapeutic group care and residential treatment is not always clearly distinguishable. Further, there are a variety of different program models for each component, such as several distinct approaches to therapeutic foster care. Some of these different models are noted in the discussion of the components.

The important service of case management is not included within the list of mental health service components. Rather, it is included as one of the operational services. It is important to recognize, however, that case management is an essential service that can play a key role in bringing together the components of a system.

NONRESIDENTIAL SERVICES:

PREVENTION

The basic goal of prevention within a mental health system of care is to reduce the incidence of emotional problems in children. As used here, the concept is equivalent to the public health concept of primary prevention. It refers to interventions directed at individuals and/or families who have not yet been identified as having emotional problems, especially those children who by virtue of genetic, family or situational factors are at the highest risk of becoming severely emotionally disturbed.

To illustrate the importance of prevention efforts, Albee (1983) offers what he describes as a homespun test of intelligence. An individual is presented with a bathtub into which water is flowing. He is given a dipper, and the task of emptying the tub of water. The intelligent solution to the problem, of course, is to turn off the tap rather than to simply try to bail out water. The application of this anecdote to mental health is that unless the flow of new children into the system is somehow diminished, the system will be left forever trying to bail out a tub that in all likelihood will fill up more rapidly than it can be bailed out, no matter how hard people work.

There are basically three main methodological approaches in mental health prevention programming (Tableman, 1982). The first approach involves the promotion of positive mental health and competencies. Many programs and curricula have been developed to strengthen youngsters' sense of identity and self-esteem and to teach them specific skills, particularly in the area of problem solving. The area of problem solving competency is emphasized because of research that has shown a linkage between skill in this area and adjustment (Spivack, Platt, & Shure, 1976). These efforts are based on the premise that the promotion of positive mental health and competencies can enhance coping abilities and, thus, reduce the incidence of future emotional problems.

TABLE 2

DIMENSION I: MENTAL HEALTH SERVICES

NONRESIDENTIAL SERVICES:

PREVENTION

EARLY IDENTIFICATION & INTERVENTION

ASSESSMENT

OUTPATIENT TREATMENT

HOME-BASED SERVICES

DAY TREATMENT

EMERGENCY SERVICES

RESIDENTIAL SERVICES:

THERAPEUTIC FOSTER CARE

THERAPEUTIC GROUP CARE

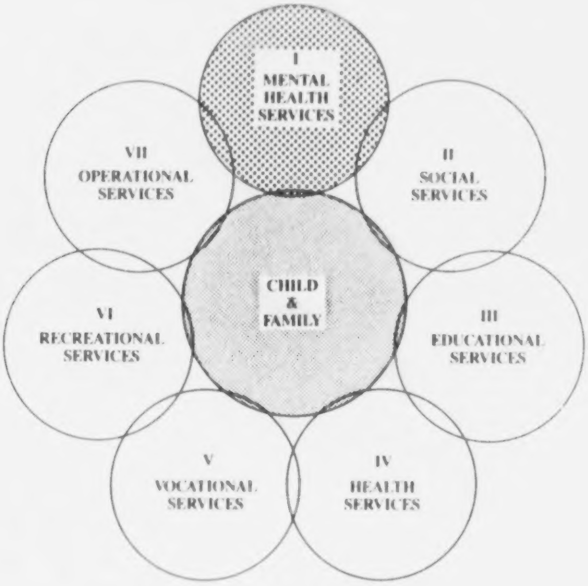
THERAPEUTIC CAMP SERVICES

INDEPENDENT LIVING SERVICES

RESIDENTIAL TREATMENT SERVICES

CRISIS RESIDENTIAL SERVICES

INPATIENT HOSPITALIZATION


I MENTAL HEALTH SERVICES
II SOCIAL SERVICES
III EDUCATIONAL SERVICES
IV HEALTH SERVICES
V VOCATIONAL SERVICES
VI RECREATIONAL SERVICES
VII OPERATIONAL SERVICES
CHILD & FAMILY

The second basic approach to prevention identified by Tableman (1982) is increasing self-help groups and support systems. This approach is based on the finding that individuals with strong and intimate relationships are better able to handle crises and stresses than individuals without such relationships. It is also consistent with the finding that abusive parents tend to be more socially isolated than nonabusive parents (Friedman, 1975). This is a particularly relevant approach with the large increases in the number of children living in single-parent households (Friedman, 1984a). Prevention campaigns, such as one by the California Department of Mental Health (1984), have been designed along this theme of enhancing support systems.

A third approach to prevention can be considered systems change. This involves making modifications in systems to increase the likelihood that individuals will encounter favorable outcomes within the system. An example is provided by the research of Felner, Ginter and Primavera (1982) on transitions for youngsters from one school to another. This research was based on the finding that at such transitional times, there is an increased likelihood that children will manifest academic and social problems. Felner et al. developed and tested a change in school procedures to provide more consistency and support for new students, and determined that such a procedure reduced the adjustment problems of the new students.

Another system change is reflected in the changes in hospital procedures which allow parents of newborn children to more rapidly hold and spend time with their newborn. Such a modification in procedures is designed to promote positive attachment or bonding between the parents and the newborn. Given the central role of schools in the development of children, system changes that increase the likelihood that children will experience success in school can be critical preventive activities.

Some efforts in the prevention area are based on the fact that in the lives of all individuals there are certain time periods that are particularly stressful. During these time periods, individuals are at particular risk for developing emotional difficulties. Some of these may be normal developmental stresses, such as when a child begins school, when a child becomes an adolescent or starts dating, or when a youngster graduates from high school and enters the work force or higher education. Other stressful times are related to specific events. High risk times for children may include parental separation or divorce, parental remarriage and the serious illness or death of a loved one. Placement in a foster home, shelter, or detention situation for a youngster can be another especially difficult time. The system of care must recognize that these stressful periods are opportune times to intervene in the lives of youngsters in order to avert the development of serious emotional problems.

Tableman (1982) suggests further that "in a prevention-minded community, children of all ages would be systematically brought into a mental health prevention program whenever a severely disordered parent becomes a client of a mental health or substance abuse agency, or enters prison."

In the 1963 address to Congress in which he proposed the Community Mental Health Centers Act, President John F. Kennedy placed a strong emphasis on the prevention of mental illness and mental retardation. One of the ways in which this emphasis was translated into the new community mental health center movement was the requirement that all centers provide consultation and education services (Bloom, 1984).

These services, considered "indirect" because they are not provided to a clinical client, were intended to extend the impact of centers by allowing them to reach more people. From the beginning they have proven to be some of the most difficult services to evaluate. In addition, as community mental health centers began to experience financial strains, and the Federal government changed legislation to eliminate required services, the emphasis on consultation and education decreased. Such services continue, however, often provided not only by mental health centers but by chapters of the National Mental Health Association, other advocacy groups, individual professionals and academicians.

The types of consultation and education activities are varied. Education activities include those that are designed to generally educate the community about mental health problems and those that are more specifically geared towards particular issues. The latter approach includes focused efforts on procedures for handling stress, for recognizing the need for mental health services, for dealing with losses, for being an effective parent or for being assertive. Some community education efforts are designed to help people learn about available services within their community.

Community education efforts include one-time public speaking engagements and ongoing classes on particular topics. They also include articles in the media, public service announcements, and distribution of pamphlets, posters, bumper stickers and other materials. These are efforts that are usually inexpensive in relation to the large number of people that they reach. However, their benefits are difficult to evaluate in terms of their impact on preventing mental and emotional problems.

Some consultation cannot be characterized as prevention per se. However, many consultation activities are preventive in nature. Consultation efforts can either be one-time or continuous, and can be focused on issues related to individuals, programs, organizations, systems or policy. Consultation may be involved in the system of care in many different ways. A mental health professional from a participating agency, for example, may meet regularly with school personnel to provide case consultation regarding students in the special education program for the emotionally disturbed. This mental health professional might also consult with classroom teachers to assist them in promoting positive mental health within the classroom and to assist them in working with children showing early signs of emotional or behavioral problems.

Within the system of care, mental health agency personnel might provide consultation to a health agency that is developing a health screening and assessment program. Such consultation might be directed at including procedures for early detection of emotional problems in the program. In another case, vocational rehabilitation professionals might provide consultation to providers within the system of care on establishing a vocational program for emotionally disturbed adolescents.

In order to achieve an appropriate balance, the system of care should devote attention and resources to a variety of programs and strategies directed at preventing emotional disturbance in children as well as to treatment programs. In recognition of this, some states and communities have increased their emphasis on prevention. For example, in Michigan an Office of Prevention has been created within the overall mental health system as an attempt to give visibility to the area of prevention, and to begin to develop, evaluate and disseminate prevention programs. In general, however, although preventive approaches generally appear to be reasonable to policymakers, such programs are often given a low priority and receive very few resources. A recent report by the National Mental Health Association Commission on Prevention of Mental-Emotional Disabilities emphasizes the need for increased preventive efforts, given the enormous human and financial cost of mental health problems (NMHA, 1986).

EARLY IDENTIFICATION AND INTERVENTION

The rationale for early identification and intervention services is that problems can be more effectively, humanely, and economically treated if the intervention begins early in the course of the problem. By so doing, the duration and severity of the problem is reduced, and the overall prevalence of emotional disturbances in children can be decreased. The early identification and early intervention efforts discussed in this section are typically referred to in a public health model as secondary prevention.

In discussing such efforts, Tableman (1982) points out that, "Considerable thought needs to be given to systematic recruitment of participants through connections with other service systems . . . If we leave it up to individuals to find us, we are getting only the most highly motivated, well-organized service seekers." Given this set of conditions, early identification and intervention efforts are almost inevitably collaborative efforts between different service systems and agencies. The key question is to identify those points of contact with youngsters and families that will provide opportunities for early identification. There are several such points of contact during a child's infancy and early childhood years. The first contact is typically with health services at the time of delivery, and then subsequently when early health services are being delivered.

The need to identify infants at risk of developing emotional problems is receiving increasing attention. A new field of infant mental health is developing under the leadership of the National Clinical Infant Center in Washington, D.C., with specialists in the field emphasizing the importance of early detection. This emphasis is focused not just on the new child but on the entire family unit. Pediatricians and nurses become important professionals for identifying problems in family functioning early, and setting the process in motion for the necessary intervention services to be provided. If the child enters day care, then staff of these facilities also become key people in the early identification process. Similarly, child welfare and public assistance workers who have contact with many families are other key parts of any comprehensive effort at early intervention.

In recognition of the importance of early detection of health problems, the Federal government initiated a program of Early Periodic Screening and Diagnostic Testing (EPSDT). However, the EPSDT program has not been applied sufficiently to the mental health area, and the screening represents a lost opportunity to identify potential emotional problems. While the program has potential for playing a major part in early identification efforts, to date it has been underutilized.

Another missed opportunity for early identification of emotional problems lies in the failure of the system to be sensitive to the perceptions of parents. Frequently, parents convey their concerns to schools, health providers and other agencies, suggesting that emotional problems may be emerging or that the child's development is not progressing appropriately. By not always attending to and trusting parents' perceptions, the system may lose valuable opportunities for early identification and intervention.

Early identification and intervention has been identified as a priority by the Office of Special Education and Rehabilitative Services of the Department of Education (U.S. Department of Education, 1985). This emphasis has been based on the finding that "Studies have shown that handicapped infants and children (and those at risk of developing handicaps) who receive early interventions show significant improvement in development and learning, along with a decrease in need for costly special education programs, compared with peers who do not receive intervention."

As the child gets a little older, then the school becomes both an important and logical place to identify children who are beginning to show emotional and behavioral problems. Headstart and other preschool programs provide ideal settings to observe children in order to detect problems. One of the best developed and most frequently replicated early intervention models in children's mental health is the Primary Mental Health Project developed by Cowen and his colleagues at the University of Rochester (Cowen, Trost, Lorion, Dorr, Izzo, & Isaacson, 1975). This program uses systematic screening by kindergarten, grade one, and grade two teachers to identify children exhibiting adjustment problems. The children are then assigned to carefully selected and trained aides who work under professional supervision and provide one-to-one, group and family interventions.

Silver, Hagin and Beecher (1981) have used systematic screening procedures to identify children showing lack of reading readiness. Their intervention, although it focuses on academic skills, has been found to be helpful not only in improving reading skills but also in reducing emotional and behavioral problems that may result from inability to succeed in academic work.

Early intervention efforts can be home-based, school-based or a combination, and may involve providing training, counseling, support and linkage with other services. Such efforts necessitate a very close relationship with other systems of service. As has already been discussed, the logical point to identify such youngsters is often when they are in contact with other systems such as health, child welfare, day care and education.

In addition, the types of problems that early intervention (and prevention) efforts address may cross many systems. For example, through more careful and systematic screening it would be possible to identify at an earlier point families beginning to experience difficulties. Such difficulties or potential difficulties may lead to such things as child abuse, physical health problems, developmental delays, educational deficiencies or emotional problems. This type of screening requires an interagency approach to early identification and early intervention rather than a more categorical approach to service. The focus should be on the child and family holistically, rather than more restricted efforts by one agency to prevent child abuse, by another to prevent emotional disturbance and by a third to prevent developmental delays, for example.

Epidemiological research has shown that amongst three and four year olds, about 30 percent show at least some signs of emotional and behavioral disturbance that merit further evaluation (Anderson, 1983). Other research (reviewed by Friedman, 1984a), shows that many of these problems of early childhood are not transient but persist over time. Given these findings, it would seem only reasonable to develop more comprehensive and systematic efforts at early identification and intervention, with a particular focus on young children. Despite the importance of these efforts for long-term progress, however, early identification and intervention services have received very sparse attention to date.

Overall, there is a need for a system to strike a balance between the prevention and early intervention services and other services for severely emotionally disturbed children. Such a balance is not easy to achieve, and is one of the major issues facing states and communities around the country. On the one hand is the recognition that there is a strong public responsibility to serve the most seriously disturbed, and that efforts to effectively serve this group have been deficient in the past. On the other hand, however, is the realization that unless effective preventive and early intervention efforts are mounted, the likelihood of ever achieving significant progress in the long run is minimal. At the same time as states and communities are dealing with the critical need to increase and improve services for the most severely disabled, policymakers must plan for 10, 15 and 20 years down the road by paying adequate attention to the prevention and early intervention aspects of the system of care.

ASSESSMENT

Assessment services are sometimes referred to as diagnostic and evaluation services. They essentially involve a professional determination of the nature of an individual or family's problems, the factors contributing to them, and the assets and resources of the individual and family. On the basis of all of this information, recommendations are made for treatment and related services, if in fact such treatment and services are indicated. The role of assessment in the system for severely emotionally disturbed children and adolescents is particularly important due to the complexity of their problems and the failure of their problems to fit into established diagnostic categories.

Assessments are generally performed when a youngster first comes into contact with an agency or an individual professional. On other occasions, a child may be referred for an assessment because he or she is failing to make adequate progress in an existing treatment program or has shown a major change in behavior. Assessments may also be specifically directed at determining the type of placement that a youngster requires. For example, the juvenile court may request an assessment to determine the type of correctional placement a child should be placed in, if any, or a child welfare agency may request an assessment to determine a child's suitability for adoption. An additional type of assessment is conducted to determine if the child is "eligible" for specific services.

In order to be consistent with the philosophy and goals of the system of care, assessment of severely emotionally disturbed youngsters must be conducted by a multidisciplinary team. This approach, specified by the Education for All Handicapped Children Act (P.L. 92-142), is based on the recognition that the multiple problems of these youngsters must be assessed in conjunction with each other in order to develop a truly meaningful intervention plan. The importance of interagency collaboration to avoid unnecessary duplication of often extensive and expensive assessments is also apparent.

Assessments involve a wide range of tools and procedures. Included should be an assessment of physical health to identify any contributing medical problems, a battery of psychological tests, an assessment of intelligence and academic achievement, assessment of social and behavioral functioning, assessment of family functioning and assessment of the child's environment. Countless tests, instruments and techniques are available for assessment of emotionally disturbed children.

Assessments of emotionally disturbed children are conducted by many of the agencies that are part of the system of care. To the detriment of the system and its clients, many of these agencies require different types of assessments utilizing different tools and procedures. Thus, emotionally disturbed children and their families may be subjected to multiple assessments from a variety of agencies. Further, many emotionally disturbed youngsters receive multiple assessments but little or no treatment or services. Assessments should be attuned to services in the community, and should serve as the basis for the development of individualized treatment plans.

While it may be agreed that a well-conducted, multidisciplinary assessment can be extremely valuable, there is much professional disagreement about the methodology and timing of assessment. For example, there is increasing recognition that a child and family often come into contact with the mental health system at a point of some severe distress or crisis. At precisely such a point, the family may be most responsive to interventions that are designed to strengthen it and to keep it intact.

In such crisis situations, intensive interventions should be immediately initiated, and assessment should be an integral part of the treatment process rather than a separate stage that precedes treatment. The immediate focus of the assessment and treatment becomes the presenting problems and the issues that are creating the crisis. The more complete evaluation can come later, after the initial situation has settled.

A related issue to be considered in determining the role of assessment is the often difficult task of engaging severely emotionally disturbed youngsters, particularly adolescents, in treatment. This is reflected in the drop-out rates of youngsters and families referred for services (Friedman & Jackson, 1985). Given this concern, it becomes important that the initial session or sessions focus on engaging the youngster or family in treatment. The professional may not have the luxury of spending several sessions on assessment, because by then the child and/or parents may have ceased to come. Some day treatment programs, such as City Lights in Washington, D.C., actually conduct an assessment over a 30 day period during which the therapist is simultaneously trying to "hook" the youngster into the program and establish a sense of trust.

The drop-out problem is diminished with assessment services provided to "captive" clients. These are clients who are either in residential settings where their physical accessibility to treatment can be assured, or who are under strong coercion to attend. Even under these circumstances, however, starting with an intensive multisession evaluation process may lose the opportunity to begin intervening at the time when the child and family are most responsive to assistance. Thus, assessments should be seen as a part of the first stage of the treatment process.

Another general concern often expressed about diagnostic and evaluation services is their time and expense. The time and cost involved in assessments reduces the number of individuals who are able to benefit from them, particularly in the public sector. One approach to this problem is the development of screening procedures that are less expensive than full-scale evaluations and can be used more rapidly. The comprehensive, multidisciplinary evaluations can then be reserved for those children who, during the screening, appear to require more in-depth evaluation or who have not succeeded in several previous intervention attempts.

The usefulness of assessment procedures with severely emotionally disturbed children is dependent not only upon the general clinical knowledge and skill of the professionals involved, but also upon their knowledge of the potential value of various services within the system of care. If the assessing individuals do not understand the potential role of day treatment or therapeutic foster care, for example, then their ability to effectively prescribe interventions is curtailed. A similar problem exists if a community system is based on the view that individuals should be treated in the least restrictive and most family-focused interventions that are available and appropriate, and the assessing professionals do not subscribe to the same view. This may be the case either because they do not have adequate knowledge about all of the services in the system of care, or they may subscribe to more individual rather than family-oriented treatment approaches.

Currently, there is an increasing emphasis on the need for a broad, ecological approach to assessment. Such an approach moves beyond traditional interviewing and psychological testing to also emphasize the broader environmental, educational and family contexts for the problem. The importance of this type of approach is illustrated by findings linking problems of children with problems of parents, marital problems, and even with the interpersonal relationships of parents outside the family (Griest & Wells, 1983). The growth of the family therapy field has also had an influence on the role and nature of assessments. The emphasis within this field is on problems resulting from family dysfunction rather than individual pathology, and the assessment and intervention processes are closely entwined from the beginning of contact with a family.

Although there is increased emphasis on ecological approaches to assessment, there are data suggesting that for youngsters with very serious problems, neuropsychological and neuropsychiatric evaluations may be helpful. Silver (1984), for example, has examined a sample of severely emotionally disturbed students within a Florida school system, and identified a variety of neurological problems.

In general, the assessment area is probably one of the most adequately funded of the mental health services. This results, in part, from its long history and tradition within the mental health field. Despite this history, however, it remains difficult in certain areas to secure the specialized professionals that are required for assessment. In particular, as Knitzer (1982) has pointed out, there are critical shortages of child psychiatrists and psychologists.

Research in the area of assessment has primarily focused on the reliability and validity of individual procedures or instruments. There has been relatively little research on the actual usefulness of the assessments in prescribing effective interventions. Nor has there been much research on the effect of the assessment process on clients, such as on how the assessment process affects continued participation in treatment, for example.

OUTPATIENT TREATMENT

Outpatient treatment is the least intensive and most typically used intervention in the mental health field. The traditional approach is for the youngster and/or family to come in to an office for regularly scheduled appointments for individual, group or family therapy. Appointments may also be for medication prescription and review. Outpatient treatment is provided in such diverse settings as community mental health centers, child guidance clinics, outpatient psychiatry departments of hospitals and health maintenance organizations. Such services are also frequently provided in the private offices of mental health professionals including psychiatrists, psychologists, social workers and counselors.

Emotionally disturbed children and their families may meet with providers one or more times per week depending upon the need. While a weekly appointment is characteristic of the traditional child guidance model, youngsters in need may see a provider as often as daily when indicated.

Typically, outpatient treatment constitutes the first approach used to try to assist a youngster and family. These services have the advantages of being nonrestrictive, relatively inexpensive, flexible and adaptable. They can be used as the only intervention for youngsters or in combination with other services both within the mental health dimension and other dimensions. For example, outpatient treatment can be used for youngsters in therapeutic group homes, in detention centers or training schools for juvenile offenders or in foster homes.

There are a variety of different conceptual approaches that may be taken to outpatient treatment. The primary approaches are psychodynamic, behavioral and family systems, although more and more frequently features of all of these approaches are being combined. Similarly, the need for multiple treatments is receiving increasing recognition. A child may be involved in individual treatment while parents are involved in marital counseling, for example.

The Joint Commission on Mental Health of Children (1969) found that there have been few studies on the effectiveness of different psychotherapies with children and youth. In fact, evaluative research on various approaches to counseling and psychotherapy has been weak, irrespective of the particular age group. Based on a review of the literature, Sowder (1979) concludes that the effectiveness of treatment seems to depend to some extent on the characteristics of both the client and the therapist, and on the quality of the interaction between them. Research indicates, however, that outpatient treatment can be helpful in working with emotionally disturbed youngsters (Casey & Berman, 1985).

The use of chemotherapy with children and youth has increased in recent years. It is estimated for example, that two percent of school children receive psychotropic drugs (Sowder, 1979). Questions have been raised about the effectiveness of psychotropic medications for severely emotionally disturbed children and adolescents as well as about the risks associated with long-term use of such medications. However, medications can be used appropriately and effectively in specific situations in combination with other treatment approaches.

In addition to psychotherapy, behavioral therapy, family therapy and chemotherapy, outpatient interventions may involve parent training, social skill training, the provision of social support and short-term problem-oriented counseling. The particular approaches used are based on the presenting problems of the child and family and the results of an ongoing assessment process.

The effective delivery of outpatient treatment can be conceptualized on a continuum, including the three important dimensions of timeliness of intervention, intensity and accessibility. These are illustrated in Figure 3.

Timeliness refers to how rapidly the service is initiated after a need for help has been stated either by a referral source or the family. Within the outpatient programs of most community mental health centers and other agencies, the rapidity of the response depends partly upon the seriousness of the problem and partly upon the availability of staff. Ideally, the agency or practitioner utilizes the "triage" concept in determining when services should be initiated. Services could then be initiated immediately for children and families in crisis situations, while children with less critical needs may be given an appointment at a later date.

Some agencies have waiting lists. In these cases, there may be a wait of several weeks before the family is seen, particularly if there is not an immediate crisis. Such

FIGURE 3

OUTPATIENT DIMENSIONS

TIMING

IMMEDIATE ↔ WAITING LIST

INTENSITY

AS INTENSE AS NEEDED ↔ 1 HOUR (OR LESS) EVERY WEEK

ACCESSIBILITY - LOCATION

OUTREACH TO HOME ↔ ONE LOCATION

ACCESSIBILITY - TIME

24 HOURS ↔ REGULAR WORKING HOURS

a wait may contribute to the problem of potential clients failing to show up for appointments, and may also result in missing the most opportune time to intervene with a family. Outpatient services with long waiting lists are at one end of the continuum of timeliness.

In contrast to this are crisis-oriented services, which respond to the child and family as rapidly as possible. Phone contact may be immediate, and the child and family may be seen by a clinician on the same day that a referral is made or assistance requested. Outpatient services with this type of short response time illustrate the opposite end of the dimension of timeliness from those programs that place families on waiting lists for several weeks prior to initiating services. In between are programs that respond within a day or two of the referral, but not on an immediate crisis basis.

The intensity dimension refers to the amount of service that a family receives. Some outpatient programs schedule families for sessions of one hour once a week or perhaps less if they have a heavy demand for services. Other outpatient programs and practitioners are more flexible, spending as much time as is needed to work with the child and family. In crisis situations, providers may spend many hours with the child and family in the belief that the intense intervention is needed to stabilize the situation. At other points in the treatment process, a weekly session with the child and/or family may be sufficient to meet the needs for ongoing counseling and support. Such flexibility is a critical variable in outpatient services to ensure that the services are responsive to the treatment needs of the child and family.

The third dimension, that of accessibility, refers to the hours in which a service is available, its physical location and its psychological accessibility. While community mental health centers and other agencies often provide some services in the evening, the majority of the services are offered during normal working hours. To maximize the accessibility of services for emotionally disturbed children and their families, it is important that services be offered during after-school and evening hours. Services are generally provided at the agency or practitioner's office, or in some cases at satellite offices chosen to increase proximity to particular communities and to thereby increase physical accessibility. In terms of psychological accessibility, the provision of services within an agency labeled as "mental health" may present a barrier to the participation of some children and families because of the stigma and negative connotations associated with mental illness. Some programs have chosen locations and names that minimize these negative connotations.

Within these extremes are a variety of outpatient programs that attempt to be as intensive, immediate and accessible as possible. For example, one successful family intervention model in Florida is called the Family Skills Team (Bobus, 1984). Within this program every attempt is made to see a new referral within 24 hours of the referral. The service is co-located with the dependency and delinquency intake in a collaborative project, so that families who are seen at intake can just walk down the hall to schedule an appointment. Since youngsters and families generally come to dependency and delinquency intake at a time of crisis, the program reaches families at a point when they are likely to be responsive to the intervention. Within this model, family therapy services are typically provided for 90 minute sessions, and often are provided several times a week during the early phases of treatment.

The trend toward the development of more intensive, immediate and accessible outpatient services seems particularly appropriate for severely emotionally disturbed youngsters and their families. There is a clear need for additional research to determine the types of children, families and problems which are most amenable to various types of outpatient services. Without question, outpatient assessment and treatment services are an important component of any system of care. It also seems apparent that a variety of types of outpatient services, varying on the dimensions of intensity, timeliness and accessibility, should be available as part of the system of care.

HOME-BASED SERVICES

Home-based interventions represent the extreme on the dimensions of timeliness, accessibility and intensity. They are crisis-oriented services, provided on an outreach basis to work intensively with children and families in their homes. Such services have been developed most prominently by the Homebuilders program in Tacoma, Washington (Kinney, Madsen, Fleming & Haapala, 1977). Although the Homebuilders model is the most well-known model, other models of home-based services also appear to be successful to the extent that they emphasize intensive, immediate, family-focused intervention.

A recent discussion of these programs in a publication of the Edna McConnell Clark Foundation (1985) identifies the following elements that home-based programs have in common:

- They accept only families on the verge of having a child removed.
- They are crisis-oriented and see each family as immediately after the referral as possible.
- They maintain flexible staff hours, including 24-hour service.
- Their intake and assessment process is designed to ensure that no child is left in a dangerous situation.
- They take a family focus rather than looking at individual family members as the problem.
- They reach out to families, typically going to families' homes.
- Their approach to intervention is multifaceted, including skill training, helping the family obtain necessary resources, and counseling.
- Services are delivered based on need, rather than on categorical placement of cases.
- Caseloads are kept small for each staff member.
- The length of the intervention is limited to a brief period, typically between two to five months.
- Families are followed up to assess their progress, and to evaluate the success of the program.

These programs have been used extensively by child welfare agencies as well as by mental health agencies. They frequently operate as collaborative interagency programs, and in Maine they are funded by joint contracts among the Departments of

Mental Health and Mental Retardation, Corrections, and Human Services (Hinckley, 1984).

Home-based programs represent radical departures from the traditional manner in which mental health services have been provided, particularly in terms of intensity. Partly because they are so different, home-based service providers often encounter resistance and disbelief. However, as one recent review concluded, "In their short history, these programs have demonstrated that many children who would have been removed from their families can best be served in their homes; that intensive services provided at a time of crisis can provide lasting improvements in family functioning; and that such services are cost-effective in relation to residential placements" (Update, 1985a).

An additional source of resistance to the initiation of these programs is the small caseload that workers maintain. Caseloads typically range from between two and four families at a time. To some policymakers, this seems to be an inefficient, if not extravagant, use of resources. The small caseloads, however, are essential to providing the immediate and intensive services.

If a counselor serves a caseload of three families and each family is served for six weeks, then in the course of a year the counselor will have served approximately 24 families. If out-of-home placements are avoided in even half of these families, then the financial savings far exceeds the cost of the counselor's salary. While it may seem advisable to try to multiply the financial savings by increasing caseload size, this tactic runs the risk of diminishing the counselor's effectiveness, and therefore decreasing the cost-effectiveness of the approach.

Home-based services are generally provided for a relatively brief period of time. At the conclusion of the service, if a counselor and family believe that additional services are needed, then the counselor assists the family in securing such additional services. Other possible models of home-based intervention might involve working over a longer period of time with families, but at a lower level of intensity, or responding not to the immediate crisis, but shortly thereafter.

Intensive home-based interventions of this type are generally provided by a team of individuals. Typically, this team involves at least three professionals. While each team member may work individually with specific families, the team approach provides support and back-up to each team member, and allows for 24-hour staff coverage. The cost for a three-person team, including secretarial and administrative expenses is reported to be in the range of $120,000 to $160,000 per year.

The limits of such intensive home-based interventions have not yet been tested. It seems clear from research findings in a number of states (reviewed by Friedman & Street, 1985b) that the services, when provided at a time of crisis, can keep many families intact. Home-based intervention programs report high success rates, both in the short-run and after follow-ups of about one year duration, on the measure of keeping children in their homes. A research project in Hennepin County, Minnesota comparing home-based interventions with regular services for youngsters judged initially to be in need of residential treatment provides important data supporting the value of these services (Auclaire & Schwartz, 1986). This suggests that if a community is committed to a family-focused system of care which emphasizes treatment in the least restrictive setting possible, then these types of services should be tried before youngsters receive out-of-home placements (with the exception of situations in which there is an immediate danger).

There are growing efforts to disseminate information about home-based interventions and to provide training in this approach. A National Clearinghouse on Home-Based services operated at the University of Iowa School of Social Work is an example of such an effort. The Kansas Department of Mental Health (1986) has developed a training package designed to instruct community mental health personnel in providing intensive intervention in the homes of severely emotionally disturbed children and adolescents at risk for out-of-home placement. The training package, entitled "Home-First Training Program," will be piloted in several Kansas mental health centers.

The use of home-based services will **not** eliminate the need for the residential components of the system of care. However, their use will help to ensure that youngsters who receive residential treatment have at least had the opportunity to participate in intensive, nonresidential approaches.

DAY TREATMENT

While home-based intervention programs are extremely intense, they are usually of brief duration. Day treatment is the most intensive of the nonresidential services that can continue over a longer period of time. Children typically remain in day treatment for at least one school year, although there are programs designed for briefer lengths of participation.

Day treatment is a service that provides an integrated set of educational, counseling and family interventions which involve a youngster for at least five hours a day. Day treatment programs frequently involve collaboration between mental health and education agencies. Even where such a formal collaboration does not exist, day treatment involves an integration of educational and mental health services. There is variability in the relative emphasis on educational and mental health interventions among day treatment programs. In addition, day treatment programs may vary in intensity.

Day treatment may be provided in a variety of settings. Some programs are conducted in regular school settings such as the Bertha Abess programs in Miami, Florida, some are in special schools such as the Mark Twain School in Rockville, Maryland, and others are conducted in community mental health centers, hospitals or elsewhere in the community such as the City Lights program in Washington, D.C. which is conducted in an independent setting. Some day treatment programs, primarily those which are hospital-based, may be referred to as "partial hospitalization" (See Update, 1985d for a review of day treatment).

Some programs are small, serving only eight or 10 students, while others are large such as the Beacon Day Treatment Program in Detroit, Michigan which has a census of 200 students and serves 23 different school districts. The specific features of day treatment programs also vary from one program to another, but typically include the following components:

o Special education, generally in small classes and with a strong emphasis on individualized instruction;

o Counseling, which may include individual and group counseling approaches;

- Family services including family counseling, parent training, brief individual counseling with parents, and assistance with specific tangible needs such as transportation, housing or medical attention;

- Vocational training, particularly for adolescents;

- Crisis intervention, not only to assist students through difficult situations but to help them improve their problem solving skills;

- Skill building with an emphasis on interpersonal and problem solving skills and practical skills of everyday life;

- Behavior modification with a focus on promoting success through the use of positive reinforcement procedures; and

- Recreational therapy, art therapy and music therapy, to further aid in the social and emotional development of the youngsters.

Most children served in day treatment programs have been through a variety of less intensive special educational programs, and have been identified as seriously emotionally disturbed in accordance with P.L. 94-142, the Education for All Handicapped Children Act. Other day treatment programs may focus primarily on youngsters in the juvenile justice system, adolescents who have dropped out of school or preschool children.

As part of a system of care, day treatment sometimes represents the last alternative to residential treatment for a child with severe problems. While day treatment may appear to be expensive in comparison with other educational programs and nonresidential mental health programs, it is very inexpensive in comparison to the cost of residential treatment programs. The costs are typically in the range of $10,000 to $15,000 per year per child, and funding frequently comes from multiple sources. The two sources most typically involved in funding such programs are education and mental health agencies, although juvenile justice, child welfare and even vocational rehabilitation agencies sometimes contribute to the funding of day treatment as well.

While day treatment is often used in an attempt to avert the need for residential placement, it is also well-suited as a transitional program to help youngsters move out of residential treatment (Friedman, 1979). In addition, day treatment can be used in conjunction with a community-based residential program such as therapeutic foster care or therapeutic group care to maximize the impact of both programs.

Both published and unpublished reports on the effectiveness of day treatment programs support the view that they are effective in maintaining many students in their homes who otherwise were likely to be removed, and in producing gains in academic and social functioning as well (Friedman, Quick, Palmer, & Mayo, 1982; Friedman & Quick, 1983; Tolmach, 1985; and Eastfield Children's Center, 1981). One recent review of day treatment programs (Update, 1985d) concluded that, "The consistent finding that programs have helped to keep youngsters in their families further indicates the importance of providing the option of day treatment to youngsters before they are placed in residential programs." Another recent review concluded that, "Most programs, regardless of theoretical orientation, consistently report positive changes in their treatment populations. Approximately 65 percent to 70 percent of treated children are reintegrated into the regular school systems. For those children not reintegrated into the educational mainstream, the prevailing impression of program staff is that program involvement at least obviates the need for residential placement" (Baenen, Stephens & Glenwick, 1986).

The collaboration of education and mental health agencies to provide day treatment services is but one manner in which these two groups can work together. Collaborative services are also important in the area of prevention, early identification, early intervention and residential services. In fact, an entire continuum of mental health-education collaborations is possible. There are many differences in perspectives, policies and regulations that sometimes interfere with effective collaborations between mental health and education systems (Street & Friedman, 1984). However, for a system of service to be effective there is a critical need to overcome these differences and for education and mental health agencies to work jointly in a wide range of collaborative efforts.

EMERGENCY SERVICES

Within the children's mental health field, crisis and emergency services have often been either totally neglected or approached in a fragmented manner. Yet this is an important set of services that serve both youngsters who are basically well-functioning but experience periodic crises, and youngsters with longer-term, more serious problems who are prone to acute episodes at which times they require special services. Although there are no data to provide specific figures, experience indicates that many youngsters enter the mental health system during times of crises, and that unless these crises are dealt with effectively, they progress further into the system.

Emergency services can be viewed as a continuum of services themselves, ranging from prevention efforts through crisis stabilization services in residential settings. This section discusses the nonresidential emergency services.

Some emergency services focus specifically on crisis prevention, identification and management. These may include educational programs to teach young people how to handle crises and to inform them of the services that are available to them. Training efforts might also be a part of the emergency service continuum. These efforts could be directed at teachers, parents, police officers and juvenile detention and shelter workers to help them identify youngsters in crisis. The training could also assist them in responding to these youngsters and in learning about available community resources.

Crisis telephone lines, which are available 24 hours a day, are an important aspect of emergency services. These hotlines with numbers that are well-publicized, offer a response that youngsters can make when they are feeling overwhelmed, confused, hurt and depressed.

Emergency outpatient services are also an essential part of any system of care. These services obviously must be accessible and readily available 24 hours a day, seven days a week. One innovation developed in New York is the use of mobile crisis teams which respond to children and families in crisis on an outreach basis. Emergency outpatient services should not only include crisis counseling, but also the capacity for emergency evaluations if these are needed. Such services should be closely coordinated with emergency residential services in case it is determined that a youngster is at such risk to injure him or herself or others that 24-hour care and supervision are needed.

Another important crisis/emergency service is the type of intensive and immediate home-based intervention that was described earlier. This service is particularly important because of its outreach into the home. A similar type of outreach into schools, detention centers and shelters would also be useful within the system of care.

The final nonresidential emergency component goes a step beyond intensive intervention in the home to actually having a counselor remain in the home on a 24-hour a day basis for a short period of time. This can provide an opportunity for situations to settle down or stabilize so that the need for hospitalization is diminished.

Currently, communities are a long way from having coordinated systems of crisis and emergency services in place. Partly triggered by increases in teenage suicides, there seems to be increasing recognition of the need for such systems, and it is anticipated that considerable progress will be made in this area in the next years.

RESIDENTIAL SERVICES:

THERAPEUTIC FOSTER CARE

Therapeutic foster care is the first of the residential options in the system of care to be discussed. It is important to note that the residential options are presented primarily in increasing order of restrictiveness. Restrictiveness, however, does not have a direct relationship with the severity of the problems of the youngsters served by the various alternatives. For example, although therapeutic foster care is considered the least restrictive residential service, there are children with extremely severe problems who have been effectively served in therapeutic foster homes after unsuccessful attempts in therapeutic group homes or residential treatment centers.

At this time, it is difficult to determine precisely which program may be best suited for a particular youngster (Friedman & Street, 1985a). The issue is not one of simply determining that particular programs are able to serve more difficult youngsters than other programs. Rather, the issue is matching the particular assets and liabilities of an individual youngster with the strengths and weaknesses of particular programs. This applies for nonresidential services as well as residential services. As previously indicated, intensive home-based interventions and day treatment programs have successfully served many youngsters with very serious problems for whom residential care was felt to be needed by professionals.

Therapeutic foster care essentially involves the following features:

- Placement of a child with foster parents who have specifically been recruited to work with an emotionally disturbed child;

- Provision of special training to the foster parents to assist them in working with the child;

- Placement of only one child in each special foster home (with occasional exceptions);

- A low staff to client ratio, thereby allowing clinical staff to work very closely with each child, with the foster parents, and with biological parents if they are available;

- Creation of a support system amongst the foster parents; and
- Payment of a special stipend to the foster parents for working with the emotionally disturbed child, and for participating in the training and other program activities.

In one sense, therapeutic foster care is simply conducting foster care at its best. Unfortunately, the large numbers of youngsters in foster care in most states, and the relatively low budgets, have hindered the development of programs that incorporate the concepts described above such as specialized training, low staff to child ratios, low numbers of children per home and the development of a foster parent support system.

Although therapeutic foster care programs share many features, there are also important differences among them. Basically, the variety of programs in existence can be divided into two categories. The first group of programs provides a relatively modest stipend to the foster parents, provides general training rather than more technical training, and relies largely on the nature of the therapeutic foster home environment, rather than any specific techniques as the main therapeutic component. The second set of programs pays larger stipends and views the foster parents more as employees than as volunteers, provides more technical training, and employs more technical procedures in the treatment of youngsters.

The therapeutic foster home programs operated in Florida (Friedman, 1983) and the Professional Parenting program operated in North Carolina by the Bringing It All Back Home Project (Jones & Timber, 1983) conform more closely to the first model. The monthly stipend in Florida is only $150 above the normal foster care rate, and in North Carolina it is about $400 above the normal foster care rate for most youngsters.

The PRYDE program run by the Pressley Ridge School in Pittsburgh (Hawkins, Meadowcroft, Trout, & Luster, 1985), and the Mentor program in Boston (Hensley, 1986) are more illustrative of the second model. PRYDE parents are provided with intensive training in behavioral procedures and put these to use on a regular basis in their homes. Stipends begin at $600 above the normal foster care board rate. Mentor parents can be paid as much as $1200 per month, and also receive highly technical training.

One of the first therapeutic foster care programs was the People Places program in Virginia which began operating in 1973 (Bryant, 1980). Most programs, however, began in the late 1970s and early 1980s. Networks of therapeutic foster care programs have grown, particularly in the states of Florida and North Carolina. Other states, such as Vermont and Maine, have fewer programs but are using them for youngsters with especially serious problems.

Among the therapeutic foster care models are the Parent Therapist program in Akron, Ohio (Gedeon, 1986; Isaacs & Goldman, 1985), Mentor (Hensley, 1986), Professional Parenting (Jones & Timber, 1983), People Places (Bryant, 1980), and PRYDE (Hawkins et al., 1985). Rather than being called therapeutic foster care, the Mentor program prefers to be called a model of Individual Residential Treatment, while PRYDE refers to itself as "foster family-based treatment."

There are a number of advantages to therapeutic foster care programs in comparison with other residential alternatives. First, they are flexible programs. Within the same program, it is possible to serve both sexes, youngsters of varying ages, and youngsters with an assortment of types of problems.

Second, such programs are relatively easy and inexpensive to start. They are the only residential alternative which requires no special physical facility. This is not only a cost savings, but also avoids the often bitter and protracted disputes over zoning. Additionally, therapeutic foster care programs can be initiated on a small scale, with only a few staff and a limited number of homes, which contributes to the low start-up cost.

Third, therapeutic foster care programs are typically the least expensive of the residential alternatives. The precise cost is difficult to estimate because of substantial differences in the size of the stipends that programs pay to foster parents. Overall, however, it is estimated that the cost of therapeutic foster care programs is in the range of $10,000 to $20,000 per year per youngster. This cost primarily accounts for payments to foster parents and staff.

While a portion of the cost of therapeutic foster care programs is generally provided by the regular foster care program in a state, the cost of specialized services is often paid separately by mental health and other agencies. This cost sharing is another important advantage of therapeutic foster care programs. Typically, the program is funded jointly by child welfare and mental health agencies. Some programs, such as Mentor, also serve developmentally disabled clients and receive funding by the mental retardation/developmental disabilities system.

Although there are no data on the optimal size of therapeutic foster home programs, it is generally recommended that such programs begin slowly and build up to a capacity of at least 15 youngsters. Smaller programs lack the flexibility to match children with foster parents and often have a more difficult time creating the all-important support system for foster parents than do larger programs.

It is also recommended that staff consist of a full-time recruiter/trainer as well as a clinical staff member for every eight to 10 youngsters. Unless there is a full-time recruiter, then these activities which are both very difficult and very important are not likely to get the persistent attention that they require. One of the major obstacles for programs to overcome is the recruitment of strong foster parents and, for this reason, it is important to have a consistent recruitment effort.

Given the relative economy of therapeutic foster care programs in relation to other residential alternatives, it would appear advisable and economical for communities to gradually expand such programs by recruiting new foster parents and adding additional clinical staff as long as the need exists. Otherwise, communities may find themselves in the position in which they place children in more expensive and restrictive programs than they might actually need.

Therapeutic foster care programs are operated by a variety of agencies -- mental health centers, residential treatment centers, local foster care programs and other family service agencies. They can be an excellent resource as part of a mini-continuum of care provided by residential treatment centers, partly because they provide a good discharge placement for youngsters as well as an alternative to initial residential placement.

Despite the growth of therapeutic foster care programs, a recent review indicates that there has been limited research related to them (Update, 1986a). Recent research by

PRYDE (Meadowcroft, 1986) indicates not only high success rates at initial discharge, but shows that 83 percent of the youngsters are still doing well in less restrictive settings two years after discharge. Research on the Florida programs (Friedman, 1983) also suggests that therapeutic foster care services are effective with a large enough percentage of children and are sufficiently inexpensive to be an important service within the system of care.

THERAPEUTIC GROUP CARE

The purpose of therapeutic group care is to provide a therapeutic environment and program to treat youngsters with emotional and behavioral problems. Therapeutic group care is provided in homes which typically serve anywhere from five to 10 youngsters, and provide an array of therapeutic interventions.

It is important to distinguish between therapeutic group care and group child care, and between therapeutic group care and residential treatment. Group child care programs are not included within the mental health services presented here because their primary mission is to provide a supportive living environment for dependent youngsters who for one reason or another are unable to live at home. These are typically abused, neglected or abandoned children. This mission differs from the treatment mission of therapeutic group home programs.

This is not to say that there are no therapeutic components within group child care programs. There frequently are such components, and this is appropriate because abused and neglected children who have been removed from their families typically require some therapeutic intervention. Without such intervention their problems may become more severe. However, while group child care facilities may provide therapy, their primary mission is to provide the supportive environment, and their primary target population is dependent children. For therapeutic group care programs, the primary mission is treatment, and the primary target population is emotionally disturbed children (although dependent children are often overrepresented in therapeutic group care facilities).

To further add to the difficulty of making clear distinctions, some facilities accept referrals both from child welfare and mental health agencies, and serve both populations. This is possible because the needs of the children may differ only slightly. The mingling of these populations may even be advisable in some cases because the less seriously disturbed youngsters can be good models and influences upon the more seriously disturbed children. A further point of confusion is that some therapeutic group care facilities as well as residential treatment centers originated as group child care programs. As the needs of the communities changed, the mission and services of the organizations changed as well.

The distinction between therapeutic group home programs and residential treatment centers is even more difficult to make, and clearly there is some overlap between the two categories. Both types of programs have the same basic mission. However, residential treatment centers generally serve large numbers of children and are organized as one large facility or several facilities on a campus. Further, residential treatment centers tend to be more medically-oriented in their treatment program and staffing arrangements. Medical staff, if not present 24 hours a day, are readily available. Within therapeutic group home programs, the approach to treatment generally derives more from social work or social-psychological origins. Additionally, residential treatment centers are more likely than therapeutic group homes to provide a high degree of "security" to prevent youngsters from running away. However, by no means is this a consistent difference between the two types of services.

The main point for communities, however, in building systems of care, is not to distinguish whether a particular program should be categorized as a therapeutic group care program, a residential treatment center or a residential school. Rather, the important point is to determine the types of youngsters the program is able to serve and the particular services that are offered. In reality, there is much overlap between the various residential alternatives in terms of the types of children served and the services provided.

A therapeutic group home is generally a single home located in the general community, which serves no more than eight children. In many cases, a single organization will operate several group homes, typically located at different sites within the community. This arrangement has an advantage in that it permits more flexibility in the placement of individual youngsters, provides more flexibility in the use of staff, and can often allow the host organization to provide more administrative, training and consultation support.

Although there are a wide variety of different approaches to operating therapeutic group homes, there are two major models that can be identified. These two models are the teaching family model, developed initially at the University of Kansas (Phillips, Phillips, Fixen & Wolf, 1974) and then transported to Boys Town in Omaha, Nebraska and the Charlee model, developed at the Menninger Clinic. Each of these models places a strong emphasis on careful selection and training of group home staff. The staff then become the key change agents on behalf of the troubled youngsters.

Both the teaching family and Charlee models employ couples who live with the residents 24 hours a day. The couples receive the assistance of relief help. Other therapeutic group home models may employ staff who rotate through shifts. This distinction between house parent models and shift models is a major one in the group home field.

The therapeutic approaches employed within the homes also vary widely. Some programs, such as the teaching family programs, place a strong emphasis on structured behavioral interventions, with a major focus on strengthening positive behaviors and teaching new skills through positive reinforcement of improved behaviors. Other frequently used interventions are group interaction and treatment and individual psychotherapy. In many cases, these interventions are used in combination.

Historically, therapeutic group home programs have primarily been in the professional domain of social work. This has occurred since many of the programs originated within the child welfare system. The treatment approaches vary, and usually involve a combination of individual psychotherapy, group therapy and behavior modification. There has also been an increase in family therapy, with a recognition of the importance of this service if youngsters are to be able to successfully return to their homes. Some programs, particularly those that serve adolescents, have also incorporated vocational training and work experiences as part of their overall treatment program. Recreation is another important aspect of the services provided by therapeutic group care programs.

There can be considerable variability in intensity of treatment among therapeutic group homes. Some programs are designed to handle children with more difficult problems, and have more staff per child, keep the number of children in the home to a relatively small number (for example, North Carolina has group homes for no more than five children), and provide more structured interventions.

The cost of therapeutic group care programs is variable. Individual group homes which serve fewer youngsters are more likely to have costs in the range of $100 to $150 per day, whereas agencies operating multiple group homes often are able to keep their per diem costs to well under $100. The key variables in cost, of course, are the intensity of the treatment program and the ratio of staff to youngsters within the program.

It is important to note that there is a shortage of effectiveness research on therapeutic group home programs specifically targeted at emotionally disturbed children. There has been extensive research on the teaching family program, but the research has primarily focused on services for delinquent children. Interestingly enough, the research seems to suggest that the program produces positive gains in the youngsters served while they are in the program in comparison to other group homes, but that the gains are not maintained after discharge (Kirigin, Braukmann, Atwater & Wolfe, 1982). The issue of achieving lasting results from residential care is a critical one.

THERAPEUTIC CAMP SERVICES

Therapeutic camp services can be considered a special category of therapeutic group care. Because camps appear to be growing in numbers and have some unique features, they are considered a separate component of the mental health services dimension.

In therapeutic camp programs, youngsters and staff live together in a wilderness situation. The very nature of the living situation presumably requires more responsible and independent behavior from the youngsters than is required in a more traditional residential setting. A heavy emphasis is placed on encouraging each youngster to be a contributing member of the group in order to help to take care of the basic necessities of living including food and shelter.

Within wilderness camp programs, a particularly strong focus is often placed on group process. Group meetings may be held not only at regularly scheduled intervals, but also as special problems develop that require attention. The treatment emphasis is on dealing with immediate situations of both a social and nonsocial nature, and the group is used to help individuals who are experiencing special problems.

The degree to which family therapy and special education are emphasized in therapeutic camps varies from program to program. Like other therapeutic group care programs, however, wilderness camp programs are showing greater recognition of the need to involve families. This requires special efforts since the programs are, by definition, not located within the communities from which the youngsters come. One approach is to have the youngsters return home to their families on a periodic basis. In addition, programs are beginning to send counselors to the families in order to involve them in the treatment to a greater degree.

These programs have the potential for helping youngsters to acquire skills and attitudes that may assist them to become self-reliant and to prepare for independence. However, the very distinctiveness of the environment of these programs offers both advantages and disadvantages. Advantages may be that the programs provide youngsters with challenging situations in which they have the opportunity to accept significant responsibilities, and they place youngsters in environments sufficiently different from their typical surroundings so that new habits may be more easily acquired. The major disadvantage is that given the uniqueness of the therapeutic environment, both the social environment with the cohesive peer group and the physical environment, the task of generalizing gains made in the treatment program back to the youngster's home community may be more difficult.

The approach of creating special environments and activities for emotionally disturbed youngsters seems to be increasing. In addition to wilderness camping, there are programs that are developing other special features, such as water and marine activities and equestrian activities. Many camps for emotionally disturbed children combine therapeutic activities and programs with a wide variety of recreational activities.

One of the larger wilderness camp programs is the Eckerd Camps, which operates five facilities in Florida as well as programs in other states such as North Carolina. Another model in this category is the Outward Bound program which has its main site in Pennsylvania and has expanded to other states as well. Such programs are developing not only within the mental health system but also within the juvenile justice system.

The growth in these programs suggests that they are filling a need in the system of services. To date, like many other components in the system of care, rigorous evaluations have not yet been conducted to permit a determination of both the short-term and long-term effectiveness of therapeutic camps.

INDEPENDENT LIVING SERVICES

Recently, there has been increased recognition of the importance of developing specific services to help adolescents make the transition to independent living. This recognition can be observed not only within the mental health system but also within the education and child welfare systems. In the special education system in particular, a priority goal is the development of services for handicapped children to help them make the transition from secondary education to work (Will, 1984).

The types of "transition" services that are needed involve both preparation to live more independently (particularly for youngsters who have no viable family to live with and who cease to be eligible for the services they are receiving when they turn 18) and preparation for paid employment. The preparation for employment requires the close involvement of the vocational education component of school systems, vocational rehabilitation agencies and job training programs.

To assist in preparing youngsters for independent living, therapeutic group care programs, residential treatment centers and day treatment programs are placing an increased emphasis on vocational training and work experience along with training in skills of independent living. Some day treatment programs, such as the City Lights program in Washington, D.C. (Tolmach, 1985), are not only emphasizing these skills in their programs but are also continuing to serve youngsters until they reach the age of 22. This crossing of traditional age boundaries is not only permissible under the Education for All Handicapped Children's Act (P.L. 94-142), but is highly desirable for adolescents and young adults with serious and multiple problems and needs.

In addition, many states and communities are beginning to develop a range of residential services to help youngsters to make the transition to independent living.

These services are new, and there is little information available about them at this time. However, within some areas of the Willie M. program in North Carolina, there appears to be a particularly strong focus on such services (Timmons, 1986).

One component of the range of residential services is a therapeutic group home situation that specifically serves older adolescents and involves training to prepare youngsters in the types of skills they will need for independent living. These programs have an explicit focus on the information and skills needed for individuals to successfully handle their needs when they are living on their own. Such skills are needed to manage financial, medical, housing, transportation, social/recreational and other daily living needs.

Another component of this set of services is apartment living with close supervision. This may involve several youngsters living together or youngsters living alone. Typically, however, agency staff will have daily contact with each youngster to help with both problem resolution and skill development. A staff member may actually live with the youngsters in the apartment or may live in a nearby apartment to provide the needed supervision, support and instruction.

The next graduated step after apartment living with close supervision is apartment living with only moderate supervision. This may involve regular phone contact with staff or staff visits only once or twice a week. This arrangement represents a gradual phasing out of agency contact as individual youngsters demonstrate that they have acquired the skills needed to live independently. It is often the last step before some youngsters actually live on their own with no formal supervision.

There is much work needed both in the area of preparation for the transition to employment and preparation for the transition to independent living. These can be very difficult goals to achieve for any youngster at the age of 18 or 19, but are particularly difficult for youngsters with emotional problems who may be without strong family support and may have minimal financial resources. Yet without specialized services to assist in this transition, many youngsters will remain unnecessarily dependent upon families and/or agencies as they enter adulthood.

RESIDENTIAL TREATMENT SERVICES

The difficulty in distinguishing the services provided in residential treatment centers (RTCs) from other residential services is illustrated by NIMH, which issues periodic reports on the characteristics of residential treatment centers. A 1983 report indicates that, "a problem in defining the universe of these facilities has always existed, that is, which facilities to include and which to exclude. This problem has been minimal with respect to highly structured RTCs which follow more of a medical model and function more like psychiatric hospitals. At the other end of the spectrum, where it is sometimes difficult to distinguish RTCs from boarding homes, halfway houses, group homes, foster care homes, homes and schools for delinquents and the like, the problem of inclusion or exclusion has been more pronounced" (Redich & Witkin, 1983). This difficulty has led to changes in the definitions used by NIMH over the years.

The report further states that "residential treatment centers for emotionally disturbed children are a somewhat heterogeneous group of mental health facilities which have one characteristic in common, that is, the provision of round-the-clock treatment and care to persons primarily under 18 years of age who are diagnosed as having an emotional or mental disorder . . . RTCs are in many ways similar to psychiatric hospitals for children, but . . . hospital facilities are generally more psychiatrically and medically-oriented than RTCs and are usually licensed as hospitals by the State in which they operate" (Redich & Witkin, 1983).

Within recent years there has been an increasing trend towards chains of RTCs and psychiatric hospitals. This includes well-known programs such as Devereux and Brown Schools. The primary source of support for such programs is third-party payments from private insurance companies with additional monies often coming from payments by public agencies.

RTCs often include a variety of different units that vary in degree of restrictiveness and security. For example, RTCs frequently have a unit that is highly secure and has a higher staff to client ratio than the other units. This unit is typically used for youngsters in crisis, who are at risk for running away or who present very serious management problems. Sometimes the more secure unit is also used at the time of admission for a youngster until a thorough evaluation is done and a placement is made in an alternative unit.

Some RTCs are organized around one large building or facility. Others are organized as a number of smaller cottages or units located on a campus. Campus types of programs may have ten or more such cottages or units. Typically, the children are divided so that they live in smaller groups with no more than 16 children. Often the individual living units have smaller capacities than 16 and resemble individual therapeutic group homes.

Campus types of programs with multiple living units are generally able to serve a wider variety of youngsters. Frequently, they have units for younger children, and other units for older children. They may even have specialized units designed to help older adolescents prepare for independent living.

Some campus types of RTCs place a major emphasis on the development of a strong sense of cohesiveness and group identity throughout the campus, and feature many "central" services. Youngsters may come together for meals and for recreational activities, for example. There may also be a central laundry, and a single educational system. Within other campuses, each unit functions more autonomously. Meals may be prepared by staff and youngsters on the unit itself, and the laundry may also be done within the unit.

As noted, in contrast to therapeutic group care programs, RTCs tend to offer a stronger medical component. However, in their recent study of residential and day treatment programs, Isaacs and Goldman (1985) noted a trend among RTCs to adopt a more psychosocial rather than medical approach. Other treatment components provided by RTCs include individual, group and family therapy, behavior modification, special education and recreational therapy. Although the philosophy and models that guide RTCs vary, there are two models that have influenced many of these programs. One is the philosophy of milieu therapy, and the other is the Re-Education (or Re-Ed) model.

The concept of establishing a therapeutic milieu is the guiding philosophy in many RTCs. A complete school program employing special education techniques is an important component of every child's treatment plan along with individual and group therapy and other services. These interventions are all viewed as components of the total therapeutic milieu which has been established as the environment in which the child can deal with his or her emotional problems. Treatment extends to the child's living arrangement where the staff is clinically trained to be part of the ongoing therapeutic intervention.

A different approach was taken by Nicholas Hobbs and his colleagues in the 1960s in establishing Project Re-Ed (Hobbs, 1979). This model focuses on the present and emphasizes building competencies. The Re-Ed model has been implemented widely. An example of the Re-Ed model can be seen at the Whitaker School in North Carolina (Isaacs & Goldman, 1985). RTCs based on this model also offer residential, educational and clinical components that combine to support a total ecological treatment environment. The Re-Ed approach also serves as the basis for other programs such as day treatment and therapeutic group homes.

Often RTCs have their own schools, either operated independently or in conjunction with the local school system. This can provide the flexibility of developing a more intense campus-based program for those youngsters who require it, while allowing those children who are functioning at higher levels to attend school in the community.

The cost for RTCs is variable, depending partly upon the facility and partly upon the specific services that an individual child receives. For example, within the same facility there may be a higher cost for youngsters requiring more one-to-one attention than for those who can function in a group setting. Most RTCs charge a minimum of $100 per day, and it is most unusual for fees to exceed $300 per day.

RTCs, particularly those with well-known reputations and multiple sites, frequently receive placements of youngsters from other states. For some states, this process of placing youngsters in centers out of state has proven to be a convenient, short-run solution to the problem of inadequate services within their own state. As the number of out-of-state placements has grown in some states, and the overall cost of these placements has increased, there has been increasing concern expressed. This has led to efforts in several states to decrease their reliance on out-of-state placements.

Placing a youngster in facilities located a considerable distance from his or her community creates problems in maintaining contacts with family, school and other key persons and agencies in the community. This can be disorienting and disruptive for children, and may also make the transition out of residential treatment, when it does come about, more difficult.

Partly for this reason, and partly for economic reasons, there has been considerable criticism of the practice of placing youngsters at considerable distances from their homes. RTCs have often been the target of this criticism. In reality, however, this problem is created primarily by system deficiencies, rather than by RTCs or other treatment facilities.

As the trend toward community-based services increases, states are making efforts to attract RTCs to their major population areas. The value of this approach depends upon the overall effectiveness of the programs and on their proper use by the communities. Their very availability and proximity may contribute to their overuse by communities, and detract from efforts by communities to develop full systems of service which include strong nonresidential components.

To some extent, residential treatment is being used for youngsters not only to meet their treatment needs, but also to meet their need for a living situation. It has been suggested that the presence or absence of a family may be as important in determining the type of treatment a youngster receives as the actual problems of the child (Friedman & Street, 1985a). Research on over 500 children in residential placements in Florida showed that in only 11 percent of the cases were both biological parents still together, and in only 26 percent did the treatment facility believe that a return home was possible for the youngster (Eberly, Kutash, & Friedman, 1984). When a follow-up of this group was done, it was determined that only 31 percent actually did return home after discharge (HRS, 1985).

In Massachusetts, a study of 114 youngsters in state hospitals indicated that 60 of them no longer needed to be placed in the hospital in order to receive treatment and were ready for discharge as long as a discharge placement could be identified (Mikula, 1986). In New Jersey, the category of Discharged Pending Placement (DPP) exists specifically for youngsters who no longer require residential treatment services but remain in the setting because they lack a discharge placement. This underscores the need for a close connection between child welfare and mental health services as well as the need for special work to be done to develop discharge placements.

The effectiveness of residential treatment for emotionally disturbed children is still largely an unresolved matter as the number of well-done studies is small. Recent reviews have examined residential and inpatient treatment both for children and adolescents (Blotcky, Dimperio & Gossett, 1984; Gossett, Lewis & Barnhart, 1983). While these reviews have indicated positive gains in many youngsters, methodological deficiencies make it difficult to interpret the data. An additional problem in assessing outcome is that by the time youngsters are placed in residential care, often their problems have been long-standing and are quite severe. Success rates with very serious problems cannot be expected to be as high as they would be with less serious problems.

The general issue of discharge placements and aftercare services is closely tied to the effectiveness of residential services. For example, Bloom and Hopewell (1982) concluded in their research that the major differences between recidivist and nonrecidivist groups following discharge were due to the post-discharge resources available to the youngsters. They concluded that, "Educational and vocational placements are likely to be the most potent forces we have available to interrupt an historical pattern of chronic psychiatric hospitalization. The results of this study provide empirical support . . . for the call for case managers, mutual planning, and educational placements of high quality for hospitalized adolescents reentering their communities. In addition, this study strongly suggests that families must receive the support services necessary to maintain their own structural integrity . . . if chronic revolving door patienthood . . . is to be avoided."

The concept of continuity of care is critical with respect to RTCs. In fact, in a follow-up study of adolescents in residential treatment, Lewis, Shanok Klatskin and Osborne (1980) conclude that "residential centers must be prepared, when indicated, to offer continuity of care through and even beyond adolescence to certain children." These types of findings have led to an increased focus on discharge planning and case management in the system of care. They have also led to a trend for residential treatment programs to diversify and offer a variety of services in order to be better able to meet the changing needs of their populations. RTCs, for instance, may offer therapeutic foster care, therapeutic group care, day treatment, case management and other nonresidential services to provide ongoing services to youngsters following discharge (Isaacs & Goldman, 1985).

A related issue concerns waiting lists for residential placements. There are three basic approaches to addressing the waiting list problem. One approach is to expand the availability of residential services, a second is to develop more alternative services to reduce the need for residential placement, and a third is to work towards more rapid discharge of youngsters already in such placements. It has been estimated that a significant percentage of youngsters receiving residential services are misplaced and do not need to be there either because nonresidential services could have kept them in their homes, or because they are ready for discharge (Friedman & Street, 1985b; Update, 1985d). The experience of intensive home-based interventions and day treatment programs suggests that this is probably an accurate assessment. Given the high cost of residential treatment, its restrictiveness, and the disruption it creates in the lives of children and their families, it seems clear that states and communities must develop a strong overall system of services so as to restrict the use of residential placements to only those youngsters with the most serious problems who have not been able to benefit from other services.

CRISIS RESIDENTIAL SERVICES

The importance of a continuum of crisis and emergency services has previously been discussed, and a range of nonresidential crisis services has been described. In some cases the nonresidential crisis intervention approaches cannot meet the needs of youngsters in acute distress. Crisis services in a nonhospital, residential context may be able to provide the level of support and intervention needed to resolve the crisis.

The goal of crisis residential services is to promote rapid restabilization and return to the home and community. The programs appear to share the following characteristics:

- They provide residential placement (shelter) during an acute crisis in a non-hospital setting.
- They are short-term.
- They provide acute and intensive treatment.
- They attempt to avert hospitalization.
- They are community-based.

A variety of crisis residential models have been developed. Sometimes referred to as "crisis shelter," these residential crisis intervention programs appear to have a role as alternatives to hospitalization. While these programs have been attempted primarily with an adult population, there is movement toward adapting crisis residential models for children and adolescents.

Crisis homes, for example, involve providing crisis services in the homes of lay persons in the community. Trained therapeutic foster parents might be available to assist youngsters in times of crisis in the foster home setting. Such a model is in operation in Vermont. Group settings, such as therapeutic group homes, might also have the capacity to provide crisis residential services to one or more youngsters on an emergency basis. In these settings, strong linkages with psychiatric and other trained personnel is essential to insure that the crisis is appropriately handled.

Crisis stabilization units represent another type of crisis residential service. Such units provide secure care with close staff supervision and intensive intervention. They are frequently located in a free-standing facility rather than a hospital, and do not have either as many total staff per client, or as high a ratio of medical staff as hospitals. As a consequence, crisis stabilization services can generally be provided less expensively than inpatient hospitalization.

To date, there has been little development of such specialized crisis stabilization units in the children's mental health field. The concept has been more widely applied for adult psychiatric patients. However, states such as Florida and South Carolina have begun to develop such units in recent years as part of their overall systems of care. The Children's Crisis Intervention Service operated by Transitional Residence Independence Services in Stratford, New Jersey is another example of a specialized crisis stabilization program for children. In an open setting, children who would otherwise have been institutionalized are treated and maintained in the community for a maximum of 28 days. Staff work intensively with the child and family to resolve the crisis and to plan for ongoing services.

Since experience with crisis stabilization units in the field is so limited, it is difficult to describe their characteristics in great detail. They are basically designed for youngsters in such serious crises that they require a secure residential placement, but who do not require hospital care.

The length of stay in such facilities ranges from several days to two to four weeks. During this time, it is important that the family be closely involved in the treatment process. It is also important that there be aggressive case management services to facilitate the placement of each youngster back in the community in a less restrictive setting with all needed services and supports in place.

Data on the effectiveness of crisis residential services are not yet available. Presumably, however, the effectiveness of such services is largely a function of their coordination and integration with nonresidential crisis services, including careful screening and intensive crisis counseling as well as with inpatient hospitalization. In addition, the effectiveness of crisis stabilization is likely to be dependent upon the availability and accessibility of a range of community services to provide ongoing care to the child and family following resolution of the crisis.

INPATIENT HOSPITALIZATION

Within a mental health system of care, inpatient hospitalization is typically the most expensive, the most closely supervised and restrictive service, and the service with the highest percentage of medical staff. It is reserved for extreme situations, for youngsters who are showing serious acute disturbances or particularly perplexing and difficult ongoing problems.

Three basic uses of inpatient hospitalization for emotionally disturbed children can be identified. The first use is for short-term treatment and crisis stabilization in cases where a child is in acute distress, and possibly presenting a danger to him or herself or others. In this case, hospitalization may last for only a few days, but more typically lasts for several weeks. The availability of short-term hospitalization for a client in crisis is a very important part of a community-based system of service. Such a service can provide a much needed back-up to less restrictive services such as day treatment or therapeutic group care. Service providers are much more willing to try youngsters in these less secure and less restrictive service settings if there is an emergency back-up facility available and accessible when needed.

A second use of inpatient hospitalization is for purposes of conducting a comprehensive evaluation. Most evaluations of youngsters can be and should be conducted on an outpatient basis. However, for youngsters who need special tests, particularly to identify neurological or biochemical components of their problem, and for youngsters who are unable or unwilling to cooperate with an outpatient evaluation, admission to a hospital can be necessary and appropriate. Such an admission is usually for a brief period, up to approximately 30 days.

A third use of inpatient hospitalization is for long-term treatment. The use of inpatient hospital settings for this purpose appears to be diminishing. Instead, other types of residential settings, such as those already discussed, are being used more frequently with the inpatient setting serving as a back-up when needed. Sometimes placements in inpatient settings that are intended to be short-term evolve into more long-term placements. This most typically results from the absence of any appropriate discharge placement for the youngster. In some states, state hospital units essentially serve as long-term inpatient settings. In other states, these state hospital units serve more as short-term units for acute care and crisis stabilization.

Some inpatient programs provide specialized services. For example, some emotionally disturbed and highly aggressive adolescents require intensive treatment in secure treatment environments. The Treatment and Rehabilitation (TRY) Unit at the Mendota Mental Health Institute in Madison, Wisconsin is an example of such a specialized inpatient program (Buzogany, 1985).

Inpatient hospitalization is the most expensive of the services in the mental health system. Costs are typically at least $300 per day, and not infrequently are as expensive as $500 per day.

Within recent years there have been large increases in the number of adolescents placed in private inpatient psychiatric settings. Recent Congressional testimony indicates that there was a nationwide increase of about 450 percent from 10,764 youngsters in 1980 to 48,375 youngsters in 1984 (Miller, 1985; Schwartz, 1985). Concern has been raised at a Congressional level that, "if such a trend is indeed taking place, it be for appropriate care, and not just a kind of incarceration" (Miller, 1985). The two issues that have been raised most frequently in this regard are whether youngsters are being inappropriately admitted to these hospitals when they could be treated in less restrictive settings, and what the overall quality of care is in these settings (Newsweek, 1986; Schwartz, 1986).

A major issue for states with regard to all residential settings is to insure that the rights of all children are adequately protected. This is especially important for inpatient hospital settings because of their restrictiveness. This issue, which until recently was focused primarily on public settings, has become more and more critical for private settings in view of the vast increases in the utilization of private psychiatric facilities for youngsters.

Many states already have statutes which prohibit placement of children or adolescents on units with adults. Other states go further and prohibit placement of children with adolescents. Most states have also developed clear guidelines for the placement of youngsters in residential settings supported by public funds. The responsibility of states, however, must now extend beyond this to insure adequate protection of rights when placements are made directly between families and treatment settings. A recent report by the United States General Accounting Office suggests that this is most likely to be the case with families that have insurance which provides mental health coverage (GAO, 1985). The responsibility of states transcends the due process issue, of course, and includes insuring that there are adequate services available within public and private hospital facilities, and that such services are of acceptable quality.

DIMENSION 2: SOCIAL SERVICES

The second dimension in the system of care includes the social services that may be needed by severely emotionally disturbed youngsters and their families. Social services are provided in order to support the functioning of family units in a variety of ways, and are often referred to as "family support services." The families of severely emotionally disturbed children may need various types of support in order to remain intact. Families often face multiple problems along with the stress of coping with an emotionally disturbed child. When a family unit cannot remain intact, social services involve the provision of services and arrangements to substitute for the family. As a result, the social services may be conceptualized as family support/substitute services, and are often of critical importance for emotionally disturbed youngsters.

Social services are frequently grouped into the three categories of supportive, supplementary and substitute services (Kadushin, 1974). Supportive services generally include supervision of a child in his or her home by a protective service worker, often coupled with treatment in a child guidance, mental health or family service clinic. Supplementary services include such services as income maintenance and home aid services including homemaker, caretaker and parent aide approaches. Substitute services, the most extreme type of social service, involve a variety of types of out-of-home placements designed either to be temporary (shelter and foster care) or permanent (adoption). Substitute services are intended for youngsters for whom supportive and supplementary services have not proven adequate to reduce the danger to the child of remaining in his or her home. As emphasized at the First White House Conference on Children in 1909, children should not be deprived of living with their parents except for "urgent and compelling reasons" (Kadushin, 1974).

Table 3 displays the services in the social service dimension, grouped within the three major areas of supportive, supplementary and substitute services. Each of the social services is briefly discussed below.

SUPPORTIVE SERVICES:

PROTECTIVE SERVICES

Protective services are designed to protect children and to "prevent neglect, abuse and exploitation of children by reaching out with social services to stabilize family life. [Such services] seek to preserve the family unit by strengthening parental capacity and ability to provide good child care. Its special attention is focused on families where unresolved problems have produced visible signs of neglect or abuse and the home situation presents actual and potentially greater hazard to the physical or emotional well-being of children" (American Humane Association, 1967).

The provision of protective services follows a "complaint" or referral, frequently from a source outside the family although often initiated by a child him or herself. If the complaint of some type of abuse, neglect or abandonment is found to be supported, then protective services may be initiated. Such services are likely to be provided if it is determined that the child can safely continue to remain at home, but that

TABLE 3

DIMENSION II: SOCIAL SERVICES

SUPPORTIVE SERVICES:

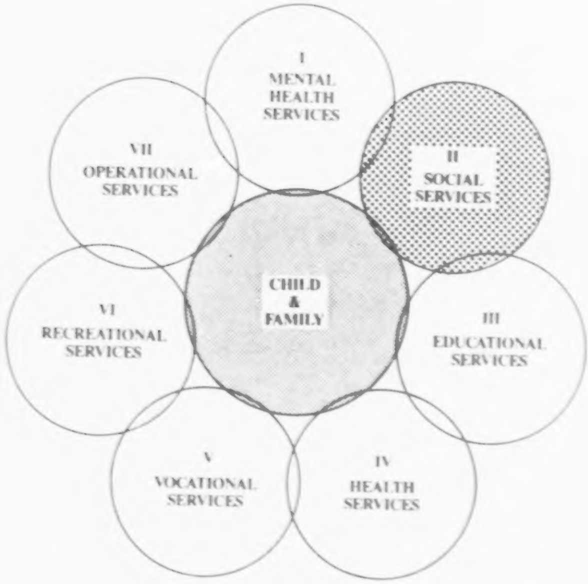
- PROTECTIVE SERVICES

SUPPLEMENTARY SERVICES:

- FINANCIAL ASSISTANCE
- HOME AID SERVICES
- RESPITE CARE

SUBSTITUTE SERVICES:

- SHELTER SERVICES
- FOSTER CARE
- ADOPTION


I
MENTAL
HEALTH
SERVICES
II
SOCIAL
SERVICES
III
EDUCATIONAL
SERVICES
IV
HEALTH
SERVICES
V
VOCATIONAL
SERVICES
VI
RECREATIONAL
SERVICES
VII
OPERATIONAL
SERVICES
CHILD
&
FAMILY

supervision of the family is needed to insure the child's safety and to assist the family in overcoming the problems that led to the maltreatment. The service continues until the child is no longer considered to be at risk of being mistreated.

In addition to the services they provide themselves, protective services workers may make referrals to mental health and family service agencies for counseling and other services. They may also seek other services to assist the family, such as financial assistance, work training, homemaker services and day care. If, however, the combination of services does not prove effective in protecting the child, then the next step is for the child to be removed to an out-of-home placement.

Within the past 20 years, there have been enormous and rapid increases in the number of complaints of child maltreatment. During the four year period beginning in 1962, after Henry Kempe had called public attention to the problem of the "battered child," (Kempe, Silverman, Steele, Droegemueller & Silver, 1962), legislatures of all 50 states passed statutes against the abuse of children by their caretakers (Pfohl, 1977). Laws requiring that both citizens and professionals report suspected incidents of abuse and neglect proliferated, and mechanisms to facilitate such reports, such as toll-free phone lines, became commonplace. Perhaps the most dramatic illustration of the effects of the new reporting laws and procedures was in Florida where the number of reports of abuse and neglect increased from 17 statewide in 1970 to over 19,000 in 1971 after a new reporting system was implemented and widely publicized (Friedman, Lardieri, McNair, Quick, Repetoksy & Stoops, 1981).

With the enormous increases both in supported and unsupported complaints of abuse and neglect, the entire child welfare system has become strained. Intake workers, charged with the responsibility of conducting the immediate investigation of such complaints, and protective service workers have experienced large increases in their caseloads and increasing demands on their time. These increases have interfered with the delivery of rapid, comprehensive and effective services.

Research has indicated a high rate of abuse and neglect among youngsters with serious emotional disturbances. For example, a study of youngsters in residential care in Florida found that of those cases for whom information was available, approximately 80 percent had documented histories of abuse and about 80 percent had histories of neglect (Eberly, Kutash & Friedman, 1984). Effective services for abused and neglected children and their families and effective liaisons between mental health and protective services workers are clearly important to an effective system of care.

SUPPLEMENTARY SERVICES:

FINANCIAL ASSISTANCE

Historically in our country, poverty and the inability of families to financially care for their children have been acceptable reasons for removing children from their homes. This practice increased with the shift from a rural, agrarian culture in which children could be an economic asset to a family, to an industrialized, urban culture in which children were a significant cost to families. In the late 19th century, one of the typical ways in which homeless children were cared for was through placement in almshouses. In addition, children from cities were often "placed out" with farm families in an exchange of child labor for child care. For example, it is estimated that between 1854 and 1929 over 100,000 New York children were so placed in "free foster homes" in the midwest (Kadushin, 1974).

The 1909 White House Conference on Children declared that poverty alone was insufficient cause for children to be removed from their families. To help make this declaration more of a reality, states began passing laws providing financial relief to families with no father, and by 1921 40 states had enacted such legislation (Kadushin, 1974).

Financial assistance remains an essential supplemental social service for families that helps to keep families intact. With large increases in recent years in the number of households with a single parent, and with over 20 percent of children found to be living in poverty, financial assistance assumes even greater importance today as a social service.

One of the areas of inconsistency among states is whether such financial assistance is provided only to single parent households or to two parent households. The provision of such assistance solely to single parent households has been criticized. This practice may destabilize families by creating a disincentive to married couples in financial distress remaining together and to unmarried parents getting married.

HOME AID SERVICES

The general goal of home aid services is to strengthen families and to help keep them intact by providing assistance in the home. Typically, home aid is provided by nonprofessionals. Home aid services are generally divided into the following three categories -- homemaker services, caretaker services and parent aide services.

Homemaker services involve providing assistance in the home with general housekeeping and homemaking responsibilities. Such services can be provided on a short-term and emergency basis. For example, a single parent may be injured or ill and unable to care for his or her children and household on a temporary basis. An emergency homemaker can go into the home to handle these responsibilities on a temporary basis, thereby allowing the children to remain at home while the parent recuperates.

Homemaker services can also be provided on a longer-term basis. A parent, perhaps because of ongoing physical or mental limitations, may need assistance with children and household responsibilities. A homemaker may come to the home one or more times each week to assist the parent. Again, this may help the children to remain at home, and may also provide a useful model both to the parent and children.

Such homemaker services, particularly on an emergency basis, were an important part of the Comprehensive Emergency Services System for Neglected and Abused Children developed in Nashville in the early 1970s (Burt & Balyeat, 1975). This project demonstrated that by developing a system of emergency responses to assist families in distress, it was possible to markedly reduce the number of children removed from their parents, even on a temporary basis.

Effective homemaker programs require careful recruitment, training and selection of homemakers. Particularly if the service is to be used on an emergency basis, it is essential that there be a cadre of trained individuals ready to provide services on a short notice.

Caretaker programs are designed to provide an adult in the home for brief periods of time when the parent(s) is unavailable. This can be on a planned or unplanned basis. For example, a parent may need to go into the hospital overnight or for several days.

If the parent is without adequate resources to care for the children, then the children may be temporarily removed from their home. This can add to the stress the children are already under due to having a parent in the hospital. As an alternative, a caretaker can come into the home and live with the children for a brief period of time, thereby preventing the need for the children to be moved.

Sometimes the need for a caretaker develops on an unplanned basis. A parent is suddenly injured or taken ill, and needs to be in the hospital or must respond to an emergency situation of some type. If a trained group of emergency caretakers is available, as in the Comprehensive Emergency Services model in Nashville (Burt & Balyeat, 1975), then a caretaker can go to stay with the children. Sometimes the length of time the caretaker may need to stay with the children is very brief. It may be only a matter of hours before a relative can be found to care for the children. However brief this time period, it is helpful to be able to keep the children in the familiar surroundings of their home.

Parent aide services are typically a planned service of providing a trained nonprofessional to work on an ongoing basis with an abusive, or potentially abusive parent. This service is based on the finding that abusive parents are frequently isolated and lacking in social supports (Friedman, 1975). The program is designed to provide an adult whose main purpose is to be supportive of the parent in the belief that such support will reduce the likelihood of the parent mistreating a child.

The adult is typically a volunteer, although this is not always the case. The adult may spend time just sitting and talking with a parent, having a cup of coffee, going shopping together, playing with the children together or whatever the parent seems to want to do and is comfortable with. This program is one example of making constructive use of volunteers. Evaluations of such programs (Cohn, 1979) indicate that they are often as effective as more expensive programs in working with either abusive families or families at risk for abuse.

Home aid services are a valuable component of the system of care for severely emotionally disturbed children. The often overwhelming demands and stress of parenting emotionally disturbed children may necessitate homemaker, caretaker or parent aide services at various times to provide needed support in the home.

RESPITE CARE

Respite care is a planned break for parents who are caring for a difficult child. Respite care is used both for biological and foster parents, and it can occur as frequently as weekly. Trained respite parents or counselors assume the duties of caregiving and supervising for a brief time period in order to allow the parents a break from the constant strain of parenting a child with serious emotional problems.

In some instances, the respite care is provided in the home rather than outside of the home. This model is akin to the model of a "babysitter." It may be for an afternoon, an evening, overnight or it may be for several days. Respite care can also be provided in a variety of types of out-of-home settings or by simply having a worker take a child on an outing for several hours to allow the parent some time at home alone. Either approach can be very supportive and helpful for parents who must cope with the seemingly never ending stresses and demands of a special needs child.

Although respite care is most frequently provided on a planned basis, on some occasions it takes place on an unplanned basis. This may be the result of a crisis between the parent and the child, or it may be because a crisis affecting the parent requires the parent to be gone for a period of time. For example, the parent may have to go to the hospital or leave town to care for a sick relative. Just the knowledge that respite care is available in case of an emergency can help a parent or foster parent who is struggling with a difficult child. In cases where the crisis is between a parent and a child, it should be noted that the first response of a social service or mental health agency should be to provide interventions in the home designed to reduce the crisis and keep the family intact.

SUBSTITUTE SERVICES:

SHELTER SERVICES

Shelter services represent the first of the "substitute" services. Shelter services are designed to provide a temporary placement, typically for no more than a few days at a time. Shelter placements are frequently used when a youngster has first been removed from his or her home until such time as a foster home or other placement can be found or the youngster can be returned home. Shelter placements are also used when a youngster has been removed from one foster care placement and is awaiting another foster care placement.

Shelter placements are typically either in home settings (including some homes that also serve as foster homes) or in group settings. The basic service they provide to a youngster is a safe and secure place to live for a temporary period of time. However, the time a youngster is in shelter is often a time of crisis. This is particularly the case for children who have just left their biological parents, or for those who have left a previous foster home in which they had lived for a significant period of time. At such a time, it is important that counseling services be made available both to help the youngsters deal with and learn from the crisis, and to try to attempt as rapid a reconciliation as is possible between the youngster and the family he or she has just left. Unfortunately, such counseling services are typically not available.

Shelter placements, although they are intended to be very brief, are often more long-lasting than originally intended. When this happens, it is primarily because of the absence of other placements for the youngster. The extended use of shelter placements occurs more frequently with adolescents than with younger children because placements for adolescents are often harder to find.

One additional type of short-term placement for youngsters is juvenile detention. This is typically a lock-up placement for youngsters who have committed offenses. The purpose of the placement is to protect the community from any further offenses by the youngster, and to insure that the youngster is available for any legal action that the courts may decide to take. Detention is a sharp contrast to other shelter services which provide the child with protection from a maltreating parent.

Detention is typically under the jurisdiction of the juvenile justice system. Other services provided by juvenile justice agencies include probation and commitment to juvenile correctional programs. These services are all in response to offenses committed by youngsters (many of whom may be emotionally disturbed), and are designed to rehabilitate the youngsters at the same time as insuring that the community is safe from repeated offenses. This range of juvenile justice services is also critical for the development of effective systems of service for emotionally disturbed children and adolescents.

A recent national meeting, sponsored by the State Mental Health Representatives for Children and Youth and NIMH addressed issues concerning the relationship between juvenile justice agencies and mental health agencies in providing services for youngsters who have committed illegal acts. As with many of the services already described, it was concluded that youngsters often require both types of services, both types of agencies have an important role to play, and collaborative efforts should be encouraged (Update, 1985b; Isaacs, 1985).

Detention placements, in particular, can represent a crisis time for a youngster. They typically occur immediately after an arrest has been made, and often represent the first such placement for a youngster. Additionally, detention centers tend to be extremely restrictive. Research indicates that youngsters placed in detention have a variety of types of mental health and substance abuse problems (Dembo, Dertke, LaVoie, Borders, Washburn & Schmeidler, 1985), and have frequently been abused as well. Counseling services for youngsters at this critical time are often lacking, but can be very helpful not only in dealing with immediate needs, but in helping to prevent future delinquent behavior. Model programs in Ventura County, California (Feltman, 1986) and Hillsborough County, Florida (Dembo, Washburn, Broskowski, Getreu & Berry, 1986) are providing such counseling services for detainees.

FOSTER CARE

Foster care in its broadest sense includes the placement of children in foster family homes, group homes, group child care facilities and residential treatment centers. These children have been removed from their homes because of abuse, neglect or abandonment, and they have either been adjudicated "dependent" by the courts or voluntarily placed in foster care by their families.

A study based on a national survey in 1977 estimated that there were about 502,000 children in foster care in the United States (Shyne & Schroeder, 1978). Of this group, 395,000 were living in foster family homes while 35,000 were in group homes, 29,000 in residential treatment centers and 43,000 in child care institutions. These numbers revealed an enormous increase in the use of foster care in the 1960s and 1970s. Between 1961, when an earlier national study had been conducted (Jeter, 1963) and 1977, the number of children in foster homes jumped from 132,000 to about three times that many (395,000). During this same time period, the population of children under age 18 in the United States increased by only 4 percent. More recent estimates are that there are about 270,000 children in foster care (Sudia, 1986).

Over the last decade, concern was raised not only about the large numbers of youngsters entering foster care, but also about the many youngsters who were remaining in foster care for long periods of time without careful planning being done to achieve permanent placements for them. For example, one study asked caseworkers about the long-range plans for youngsters in their caseload, and found that for 66 percent of the children the plan was foster care until the youngster reached the age of majority (Wiltse & Gambrill, 1974). A second study, focusing only on adolescents in foster care, found foster care until reaching the age of majority to be the plan for 82 percent of the youngsters (Friedman, Quick, Garlock, Hernandez, & Lardieri, 1979).

This problem of youngsters remaining in a placement that was intended to be temporary for excessive lengths of time became known as "foster care drift." As

Maluccio & Fein point out (1983), "Concern about the phenomenon of drift in foster care has given rise to the practice called permanency planning--the process of taking prompt, decisive action to maintain children in their own homes or place them permanently with other families." Much of the pioneering work of the permanency planning movement was done at the Regional Research Institute at Portland State University (Emlen, Lahti, Downs, Glen, McKay, & Downs, 1977). According to this group, the concept of permanence for a child includes the following features:

- Intent - A child is in a home that is "intended to last indefinitely."
- Commitment and continuity - The family is committed to the child and continuity is provided in the child's relationships with family members.
- Legal status - Rather than the child being left in limbo, the family provides the child with a definite legal status.
- Social status - The child no longer suffers from the lower status of being without a permanent family but now has the status that a family provides.

The concern about the problem of foster care drift and the need for permanency planning also gave way to the passage in 1980 by the U.S. Congress of the Adoption Assistance and Child Welfare Act (P.L. 96-272). This act was designed to provide incentives for states to develop preventive services to try to maintain children in their own families, to provide subsidies to assist in adoption of special needs children, to periodically and systematically review the status of all children in foster care, and to maintain good and complete information systems about children in foster care.

Foster care is an important service for youngsters, and a key component of a community's overall system of care for emotionally disturbed children. An effective foster care program requires adequate staffing ratios of caseworkers to children, well-trained caseworkers, a sufficient number of foster homes, carefully recruited and trained foster parents, careful case planning, close work with biological parents, and a variety of support services for children, biological parents and foster parents. A relatively detailed set of standards for foster care was developed by the Federal government in conjunction with the American Public Welfare Association (1979) for use by states in assessing their foster care services.

Therapeutic foster care as a special mental health service was discussed previously. Many more children in foster care could benefit from the specialized services of such therapeutic programs than typically receive them. As a consequence of the lack of resources available to foster care programs, youngsters who have already suffered the trauma of being removed from their biological parents often are placed in overcrowded or inadequate homes, bounce from one home to another, do not receive the types of services they need, and, as a result, develop even more serious problems. The need for strong foster care services is essential if an effective system of care both to prevent and treat youngsters with emotional problems is to be developed.

ADOPTION

In contrast to other substitute placements, adoption is intended to be a permanent rather than a temporary placement. It is designed for those situations in which return to the biological parents is unlikely for a youngster. In such situations, the biological parents may have abandoned the child and their whereabouts are unknown, they may have indicated a lack of willingness to have the child back, they may continue to practice the same types of behaviors that placed the child at risk or resulted in abuse before, or they may have refused to make the types of changes needed for the child to return home.

A major concern related to the child welfare system in the 1960s and 1970s was that in cases where it did not appear that the child would ever be able to return home to the biological parents, agencies were slow to initiate proceedings to terminate the rights of the parent so that the child was freed for adoption. Contributing to the problem was the fact that judges were often reluctant to go along with proceedings to terminate parental rights, and proper statutes and policies were not in place to facilitate this process. Also lacking were procedures to insure that adequate efforts were made to assist biological parents before requests to terminate their rights were made.

As reported in the 1979 report of the National Commission on Children in Need of Parents, "The course of wisdom in dealing with an uprooted child is to try to return that child to his or her original home, or, where this is not possible or sensible, to have the courts make a timely determination that the parents' rights are terminated and the child is free to be adopted." This issue was a major focus of the 1980 Adoption Assistance and Child Welfare Act which also prompted states to provide adoption subsidies to assist in the adoption of special needs children (e.g., children with physical or emotional handicaps, sibling groups, older children and minority children). The adoption subsidies were designed both to assist low income families (some of whom were foster families) to be able to afford to adopt a special needs child, and to assist families in adopting children whose physical condition might result in excessive medical expenses.

In the past ten years, there has been significant progress in adoption of children with special needs. Often times, children with very serious handicaps, who previously might have been considered "unadoptable" have been placed. Adoption of special needs children, however, is not easy either for the child or the adopting family. Services above and beyond what have traditionally been provided to families who adopt healthy infants are often needed.

In Mercer County, Pennsylvania, a special project of the Children's Aid Society is focusing on the need for mental health services in the adoption process. An example of their activities is a conference on "Mental Health Strategies with Adoptive Families" to share programs and ideas for meeting the mental health needs of adopted children and their families. The Mental Health Association in Butler County, Pennsylvania provides training and resource materials for mental health professionals on issues related to foster care and adoption.

Further, as more children with serious problems are placed in adoptive homes, it is not surprising that there are more "adoptive failures" in which the youngster is returned to the custody of the social service agency. Such failures not only emphasize the difficulty of such adoptions, but also underscore the need for additional mental health services for the child. The experience of leaving a placement that was designed and intended to be permanent can be extremely traumatic.

Adoption, particularly of special needs children, is another important component of an effective system of care for emotionally disturbed children. It is yet another area, like all of the other social services that requires interagency planning and collaboration in order to insure that the full range of services needed by a child and family are provided.

DIMENSION 3: EDUCATIONAL SERVICES

The educational system plays a critical role in the development of all children. It can help to promote healthy growth and development, prevent emotional and behavioral problems, identify children at an early age who are showing such problems, and provide services to help children with special problems. Like all children, emotionally disturbed children are entitled to an education. In most cases, however, special educational programs and services are required in order to help them to learn. Consequently, a strong educational dimension is crucial to an effective system of care for troubled children. The educational services dimension is displayed on Table 4.

The major piece of Federal legislation affecting services for seriously emotionally disturbed children is the Education for All Handicapped Children Act (P.L. 94-142), passed by the United States Congress in 1975. This landmark legislation was designed to guarantee the right of all children, regardless of any handicap, to a free and appropriate education.

One of the purposes of the law was to establish responsibility for serving handicapped children. In the absence of clear responsibility, handicapped children were either inadequately served within the public schools or were excluded from participating in the schools. The law stipulates that schools are responsible for providing an education for all handicapped children. It includes a number of protections for children during the identification and certification process, and requires that an individualized educational plan be developed for each child identified as handicapped under P.L. 94-142.

The law further states that schools are responsible for providing related services such as "transportation, and such developmental, corrective, and other supportive services (including speech pathology and audiology, psychological services, physical and occupational therapy, recreation, and medical and counseling services, except that medical services shall be for diagnostic and evaluation purposes only) as may be required to assist a handicapped child to benefit from special education." Despite this language, however, there remains substantial confusion about whether schools are in fact obligated to pay for psychotherapy or counseling. Consequently, children are often not receiving needed psychotherapy or counseling services (Knitzer, 1982).

A similar problem exists with regard to residential treatment for severely emotionally disturbed children. Despite the attempt to clarify responsibility through P.L. 94-142, in practice there is little consensus concerning payment for such services. In some states and communities there is a specific cost-sharing agreement between education and mental health agencies for residential placement, while in many states the problem has not yet been resolved.

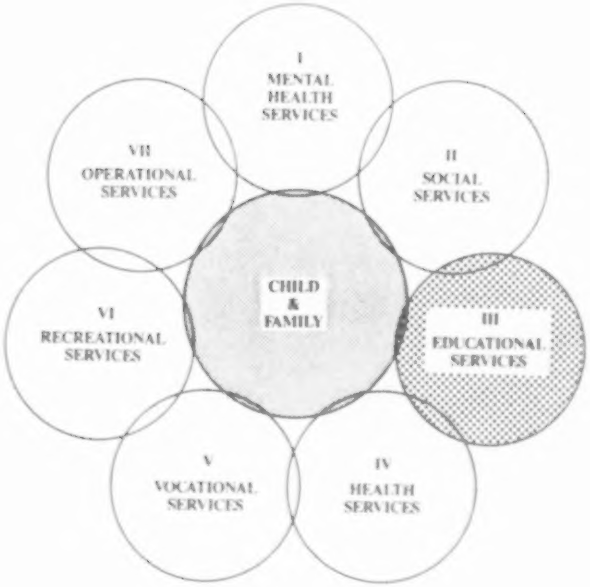
Data released by the U.S. Department of Education indicates that there were 4,366,957 children identified as handicapped during the 1984-85 school year, of whom, 373,307 were identified as emotionally disturbed (8.54 percent). Overall, emotionally disturbed children comprise .9 percent of the public school population. While this represents a gradual increase since the passage of P.L. 94-142, it has been noted that these figures are considerably below accepted prevalence estimates for severe emotional disturbance among children (Huntze, 1986).

One of the sources of the discrepancies between the overall prevalence rates for emotional disturbance and the number of children served in the public schools relates to children who manifest conduct and behavior problems. These youngsters, whose

TABLE 4

DIMENSION 3: EDUCATIONAL SERVICES

ASSESSMENT & PLANNING
RESOURCE ROOMS
SELF-CONTAINED SPECIAL EDUCATION
SPECIAL SCHOOLS
HOME-BOUND INSTRUCTION
RESIDENTIAL SCHOOLS
ALTERNATIVE PROGRAMS


I
MENTAL HEALTH SERVICES
II
SOCIAL SERVICES
III
EDUCATIONAL SERVICES
IV
HEALTH SERVICES
V
VOCATIONAL SERVICES
VI
RECREATIONAL SERVICES
VII
OPERATIONAL SERVICES
CHILD & FAMILY

behavior often includes disruptiveness, aggressiveness and noncompliance, represent a high proportion of children served in the mental health system as well as the juvenile justice system. Within the school system, these children have often been called "socially maladjusted." There has been debate about whether they are also "emotionally disturbed" and what the responsibilities of the school system are for these youngsters. P.L. 94-142 excludes socially maladjusted children from being considered "handicapped," unless they are also emotionally disturbed or have some other handicapping condition, thereby leaving room for interpretation. The process of distinguishing between an emotionally disturbed child and a socially maladjusted child is, at best, very difficult.

In analyzing this situation, Neel and Rutherford (1981) have pointed out that in a situation of definitional ambiguity, there is no incentive to identify a particular group of youngsters unless there is an effective set of treatment, training and education procedures for them. They indicate that, "No clear definition exists because of the confusion between legal, social and educational parameters. Definitions have been a problem in many areas, not just with regard to the socially maladjusted. A similar problem has plagued those who try to identify learning disabled children. Definition cannot be the real complaint. Lack of successful intervention strategies may be the real reason for the reluctance to include socially maladjusted children under P.L. 94-142. If socially maladjusted is acknowledged as a handicap, then these children would have to be served. They could not be excluded or expelled from schools. Thus, the school would be required to provide programs, and many districts are not sure they can. It is easier not to include these children, to rely on the intervention of exclusion." It has also been charged that school districts, concerned about cost containment, are reluctant to allocate additional monies for the special education of "socially maladjusted" children.

A recent analysis of the data on youngsters identified and served as emotionally disturbed in the public schools shows considerable variability among states (Update, 1985c). For example, in seven states the percentage of handicapped children who were categorized as emotionally disturbed was at least 15 percent and ranged as high as 28.9 percent in Utah. For seven other states, the percentage of handicapped children who were identified as emotionally disturbed was less than three percent, and ranged as low as .08 percent in Mississippi. To further highlight the inconsistencies among states, it was found that there were six states which served more students as emotionally disturbed than as mentally retarded (Colorado, Connecticut, Delaware, New Jersey, New York and Utah), while in seven states there were over seven times as many mentally retarded students as emotionally disturbed (Arkansas, Kentucky, Indiana, Mississippi, Ohio, Oklahoma and Vermont).

To guide programs for severely emotionally disturbed students, each state education agency develops policies for the state which are in compliance with P.L. 94-142. It is this set of policies that local districts use to establish their programs and services for emotionally disturbed students.

Two elements of P.L. 94-142 are of particular importance in considering education as a dimension of the system of care for severely emotionally disturbed children. The first is the process of identification and certification of children as eligible for services. The second is the concept of service in the least restrictive environment. Local districts must adhere to specific regulations which define who may be served under the severely emotionally disturbed label, how they must be identified and how the type of educational placement must be determined.

In the decade that P.L. 94-142 has been in existence, several evaluations of these procedures have been conducted. An extensive literature describing the results of these analyses now exists. While it is true that much controversy exists over the process of identification and even over the use of the label "seriously emotionally disturbed" (see report by SRA Technologies, 1985), there is general consensus that P.L. 94-142 has brought about many positive changes in the provision of services to severely emotionally disturbed youth.

The procedures and service options used by the educational system in working with severely emotionally disturbed students are shown on Table 4 and are reviewed below. While there are differences from state to state in terminology and procedures, general principles for providing educational services within the system of care are presented.

It should be recalled, however, that in addition to services for children already identified as emotionally disturbed, schools can and sometimes do provide a range of services to prevent emotional disturbance or to identify children with problems before the problems become serious. Because of the large number of children served by the schools, and the great impact that schools have on children, schools are a natural locus for prevention, early identification and early intervention efforts. Some of these efforts have been described in the preceding sections on prevention and early intervention. To aid in these efforts, there is an important need to train teachers, through pre-service and in-service education programs, to identify, understand and work with children with emotional problems.

ASSESSMENT & PLANNING

One of the major guidelines of P.L. 94-142 prescribes that identification and placement of children for special education programs must be the result of an assessment by a multidisciplinary team. Further, this assessment must include a variety of methods and measures.

Of all the exceptionalities covered under P.L. 94-142, the learning disabled and the emotionally disturbed categories have presented the most difficulties for diagnosis. The definition of serious emotional disturbance stated in the Act has been criticized as being too general and vague (Kauffman, 1985). P.L 94-142 defines emotional disturbance as "a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which adversely affect educational performance: (a) an inability to learn which cannot be explained by intellectual, sensory, or health factors; (b) an inability to build or maintain satisfactory interpersonal relationships with peers and teachers; (c) inappropriate types of behavior or feelings under normal circumstances; or (d) a tendency to develop physical symptoms or fears associated with personal or school problems (Federal Register, 1977).

In the process of diagnosing severely emotionally disturbed children, a variety of methods are used ranging from observation to behavior checklists to projective tests. Many states require an evaluation by a psychiatrist in making a diagnosis of severe emotional disturbance. In spite of all these procedures, it should be noted that experts on best current practice in assessment agree that such decision making, regardless of technique used, is somewhat subjective (Wood, Johnson & Jenkins, 1986). Problems of diagnosis notwithstanding, children are eventually identified by the school system and placed in a special program for severely emotionally disturbed children.

Before actually beginning a program, each child must, by law, have an individual educational plan (IEP). In the case of a severely emotionally disturbed child, the assessment team is faced with the issue of balancing "behavior versus academics." There is much variability among programs in the degree of emphasis placed on addressing the emotional problem of the child versus academic achievement. Such decisions are very often subject to local program constraints, but neither area should be emphasized to the exclusion of the other.

Another area of controversy in the development of IEPs for severely emotionally disturbed children is the recommendation of psychotherapy as a "necessary related service." Under the provisions of P.L. 94-142, exceptional students are entitled, at public cost, to those related services which are necessary so that they may benefit from special education. The issue of whether or not psychotherapy is such a service has yet to be resolved. Consequently, very few children who have been identified as being seriously emotionally disturbed by the public schools are receiving psychotherapy (Grosenick, 1981). This is in spite of data indicating that psychotherapy for children does have a beneficial effect (Casey and Berman, 1985).

The difficulties encountered in identifying and developing plans for severely emotionally disturbed children are formidable, and are often a source of frustration for school personnel. However, the barriers to effective service delivery that arise because of these difficulties are not insurmountable. The human resources burden placed on the educational system can be alleviated to some degree by creative interagency coordination. For example, placing a mental health professional on the multidisciplinary team is a relatively easy administrative task that can have a profound effect on the services provided to severely emotionally disturbed youth, both through direct and indirect means. The mental health professional can be instrumental in identifying and accessing mental health services through mechanisms with which school personnel are not familiar. More indirectly, an in-service training need, such as positive approaches to discipline, might be identified and met by the mental health professional in a consultive relationship with school personnel.

Thus, it is evident that education must be viewed as a component in the system of care, and that all of the components must be interactive and complementary for services to have the maximum possible benefit. Interagency linkages are necessary not because of the weaknesses of the educational system, but rather because no agency is capable of meeting the multiple needs of severely emotionally disturbed children in isolation.

As mentioned previously, the concept of least restrictive environment is the guiding principle in determining what type of special education service a child shall receive. The school program for children with emotional problems is essentially a continuum of service delivery options ranging from resource rooms in regular schools to full-time placement in a special school. The type of placement is determined when preparing the IEP, with input from parents and the student if feasible.

Just as the concept of balance was raised in describing the total system of care, the issue is relevant with respect to the education dimension. A school system must have an adequate number of slots available at each level of restrictiveness to ensure that a child will receive the correct type of placement. If, for example, a school only has self-contained classes, a child may experience difficulty in returning to a regular class without the transition support that a resource room could supply. Conversely, if a child is seriously disturbed and there are no openings in a self-contained class, the child may present too much of a challenge for a resource room environment. The results may be not only deleterious to the child, but also to the other children in the program.

The problem of planning adequate service units is especially difficult for special education directors since they often have to plan a budget during the preceding school year based on estimates of the number of children in need. A few children moving into the district and needing placement, along with some newly identified children, can cause a real strain on services. Thus, a school district should maintain a well-balanced continuum of placements with flexibility that will allow for unanticipated cases.

RESOURCE ROOMS

Many emotionally disturbed children can be adequately served in the schools with the assistance of a resource room (SRA Technologies, 1986). This is the least restrictive option and can be used as a support for children with mild or moderate problems who have been identified early as well as for those children who are being stepped down from more restrictive settings. The usual organizational pattern is for the special teacher to have a fixed roster of students for one or two instructional periods each day. During any period, the teacher should have a group small enough to allow for individual attention. This number is a function of the type of children in the class, but most often ranges from four to six. More children can be served if a teacher aide is used to assist the resource room teacher. For the maximum teacher flexibility in dealing with crisis situations, a teacher aide is indispensible.

In addition to direct service to children, the resource room teacher can also serve as a consultant to the regular classroom teachers in the school. This consultive model of service delivery is relatively new and has demonstrated success. The special education teacher generally engages in two types of consultation. The first type of consultation focuses on those students who are placed in the resource room. In the second type of consultation, the resource room teacher consults about other children by virtue of being accepted as an expert in behavior problems.

In the first case, the teacher/consultant's goal is to enhance the functioning of the child in the regular classroom situation. The regular teacher needs information about the child's strengths and weaknesses as well as information about effective methods of motivation. Often, a student is involved in some type of point system which must be coordinated by the special educator. Frequent communication among all the teachers involved with the child is essential for maximizing success.

When communication is good and the special education teacher is respected by peers, instances of the second type of consultation will increase. In this case, the specialist is called upon for help with a behavior problem that is vexing a particular teacher or perhaps for help with a school-wide problem. In these situations, the specialist can do much preventive work and can facilitate early identification of emotional problems. Administrators should be aware of this function of the resource room teacher (or any special education teacher), and should allow for such consultation when planning schedules.

SELF-CONTAINED SPECIAL EDUCATION

The next level of restrictiveness on the continuum of educational placement is full-time placement in a self-contained special education classroom. In this type of placement, intensive support and supervision are offered in a relatively structured environment. This type of program is appropriate at both the elementary and secondary levels for children who have serious emotional problems. Class size typically does not exceed eight students, and a teacher aide is essential to assist the special education teacher. The special education teacher in this type of placement is responsible for the total educational program of each child. Nonacademic subjects such as physical education, art and music are ideally taught by specialists, although this is not always the case, particularly in smaller school districts.

Since students in self-contained classes have severe problems, their IEPs should contain well-articulated goals and objectives aimed at improved behavior. The technique most frequently employed to achieve such improvements is some type of behavior modification program. There are many other therapeutic techniques used by teachers, with reality therapy (Glasser, 1969) and self-concept building (Dinkmeyer, 1973) among the most widely used. Parent involvement in these intervention techniques is an important factor in predicting success, and, of course, varies greatly from school to school.

The teacher is the primary agent of change in self-contained classes with some support offered by a consultant from a mental health agency or from the school psychologist, guidance counselor or social worker. These mental health professionals might provide consultation to the special education teacher as well as direct counseling services to the students. A regular program of group or individual sessions by these professionals is often provided to students in self-contained classes.

In many cases, children in self-contained classrooms are taking a psychotropic medication. The teacher should be given adequate information about the effects and possible side effects of such medication. Likewise if a child is receiving psychotherapy at a community agency or from a private practitioner, there should be some regular feedback to the teacher to enhance the effectiveness of both the therapy and the educational program (Casey and Berman, 1985).

While self-contained classes can be an effective component of the system of care, all too often administrative procedures diminish their effectiveness (Grosenick & Huntze, 1981). There are two major factors that can compromise the effectiveness of special education classes. First, class size too often exceeds acceptable limits. It should be acknowledged that the addition of just one more emotionally disturbed child can cause a significant problem for the teacher. The second factor relates to class make-up. There may be too wide a range in ages or level of functioning within a single class. This could result, for example, in a situation in an elementary program in which children from six to twelve years of age are placed within the same self-contained class. Educational levels might vary within a high school class such that the reading level of students ranges from grade equivalents of 4.0 to 10.5. The teacher in each of these classes would be hard pressed to develop activities that would appeal to more than just two or three students, although a hallmark of special education is individualized educational programming. Extreme variability in the type of emotional problem of students can also have a negative effect on outcome.

SPECIAL SCHOOLS

In some cases, the emotional problem of the child exceeds that which can be adequately treated in a classroom within a regular school building. In these situations, the next option on the continuum of educational placements is a special school. These schools are nonresidential and provide a full-day educational program for emotionally disturbed children within a facility that is separate from the regular school.

Special schools may deliver programs for students with a variety of handicaps or may exclusively serve emotionally disturbed youngsters. These schools sometimes have intensive mental health components, not unlike day treatment programs. They often attempt to address both the mental health and educational needs of the child in a highly specialized and structured setting.

In terms of treatment and placement within the system of care, special schools are often viewed as the last alternative before removal from school and community to a residential treatment center or school. This negative connotation is detrimental not only to the students currently placed in special schools, but also to the potential for such schools as a step down from residential placement. In recent years, many exemplary special school programs have been established.

HOME-BOUND INSTRUCTION

A much abused, though legal, option for educating certain severely emotionally disturbed children is through home-bound instruction (Grosenick & Huntze, 1983). The school district arranges for the child to receive instruction at home, usually for no more than five hours a week.

This option is often used in the most serious cases of disruptive behavior, and should be considered only as a transition to a more effective and appropriate placement. Unfortunately, home-bound instruction is too often a transition to dropping-out and the termination of services. This service should only be used for short-term, time-limited educational intervention. It is incumbent upon members of multidisciplinary teams to be vigilant about the potential abuse of home-bound instruction. Situations in which home-bound instruction is required can be viewed as opportunities to advocate for more slots in appropriate placements or for new programs to meet the needs of severely emotionally disturbed children.

RESIDENTIAL SCHOOLS

The most restrictive service on the continuum of placements in the educational system is a residential school. In most cases, residential schools are not in the child's home community, and may even be located in a different state. In making the decision for such a placement, the multidisciplinary team is usually joined by a state level review committee which must approve such a placement.

Residential schools are intensive treatment centers that are not hospitals, but rather school-focused programs at which children reside. It is difficult to differentiate residential schools from the RTCs described previously. In fact, the differences may be negligible or largely semantic. A number of RTCs refer to themselves as "schools," and both offer residential, educational and clinical components.

The issues and concerns that surround residential schools are similar to those raised in discussing residential treatment. The restrictiveness of the placement, the difficulty in involving parents in the treatment program, and the doubts about having truly exhausted possible community-based alternatives prior to making the placement are factors that must be taken into account when considering a residential school placement. Residential schools, however, are appropriate to the needs of some children.

The major characteristic of residential schools is that the educational component is a dominant factor in the child's treatment plan. It should be noted that these residential schools for emotionally disturbed children are different from state training schools which are typically secure residential facilities for adjudicated delinquents with an emphasis on the rehabilitation of delinquent behavior.

ALTERNATIVE PROGRAMS

Some school districts are beginning to meet the needs of children with emotional problems through "alternative" programs. Children served in these programs are not formally identified as "emotionally disturbed." There are no established guidelines for these programs, and they are not governed by P.L 94-142. Further, there are no Federal special education funds available to support alternative programs forcing school districts to operate such programs out of their local budgets.

The advantage offered by alternative education programs is flexibility. Many children in need of special help are labeled socially maladjusted rather than emotionally disturbed. As a result, they are not eligible for placement in a program for the emotionally disturbed under P.L. 94-142. Yet these youngsters cannot function in the regular classroom setting, and they become high risks for dropping out. Very often there are no real differences between these children and those who are diagnosed as severely emotionally disturbed (Grosenick and Huntze, 1983).

Typically, alternative programs operate on a small scale and may have only one teacher and an aide. In other cases, school districts may provide a fully staffed and separate alternative school. These alternative programs often are the focus for creative interagency cooperation. For example, the local mental health clinic may supply staff or a drug and alcohol program may supply a trained therapist. Creative uses of staff and facilities can lead to programs that have real impact on troubled youth and keep them in school (Duchnowski, 1983). As the number of children identified as needing services increases at a rate faster than budgets increase, school systems may need to explore the creative use of educational alternatives.

DIMENSION 4: HEALTH SERVICES

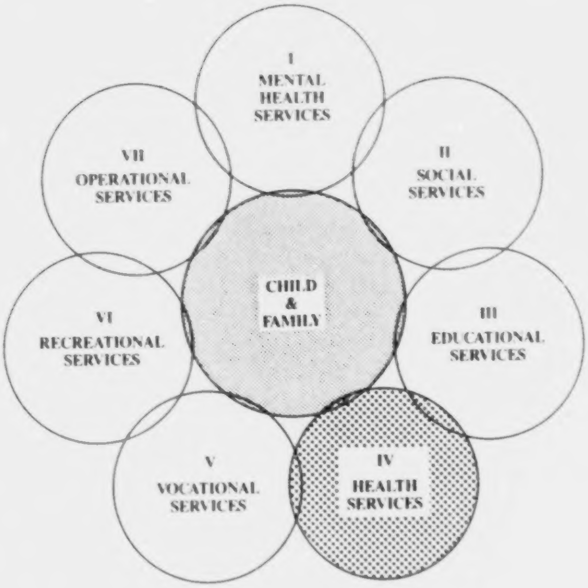
Table 5 displays another critical dimension of the overall system of care, that of general health services. There is evidence to indicate that emotionally disturbed children and other children involved in specialized public services may have more health problems and medical needs than the general population. For example, a study of children in the most restrictive mental health placements in Florida showed that 17 percent of the youngsters had some type of nervous system disorder, 10 percent had a skeletal disorder, 14 percent had a sensory dysfunction and 38 percent had some other medical problem. These figures are conservative estimates because they are based only on information available from case record reviews. In this sample, 47 percent of the youngsters were receiving at least one psychotropic medication (Eberly, Kutash and Friedman, 1984). In a study based on clinical examination of youngsters in a public school-operated program for severely emotionally disturbed youngsters, Silver (1984) found evidence of neurological problems in almost one third of the group.

It is increasingly recognized that physical health problems can contribute to, exacerbate or underlie emotional disturbances. The detection and treatment of health impairments ranging from vision and hearing problems to chronic illnesses is critical

TABLE 5

DIMENSION 4: HEALTH SERVICES

HEALTH EDUCATION & PREVENTION
SCREENING & ASSESSMENT
PRIMARY CARE
ACUTE CARE
LONG-TERM CARE


I
MENTAL HEALTH SERVICES
II
SOCIAL SERVICES
III
EDUCATIONAL SERVICES
IV
HEALTH SERVICES
V
VOCATIONAL SERVICES
VI
RECREATIONAL SERVICES
VII
OPERATIONAL SERVICES
CHILD & FAMILY

for all children, and especially important for children identified as emotionally disturbed.

Health care services for emotionally disturbed children and adolescents are provided in various types of settings and facilities. Private health practitioners such as pediatricians and family practitioners provide a wide range of health services ranging from preventive and primary care to long-term care for chronic medical conditions. Health care is also provided through public health clinics, hospital outpatient clinics, ambulatory care centers, health maintenance organizations and other facilities.

Health services provided to severely emotionally disturbed children and youth should be comprehensive, encompassing routine health examinations and follow-up care for any identified health problems. In addition to the more typical childhood ailments, health services must address a host of new health problems which are increasingly afflicting today's adolescents. Among these problems are alcohol and drug abuse, teen pregnancy, sexually transmitted diseases, suicide and violent behavior. The Children's Defense Fund (1986) terms these problems "the new morbidity," and reports that they are among the leading causes of disability or death among American youth. It can be assumed that severely emotionally disturbed youth would be at particularly high risk for many of these health problems.

In response to the changing nature of the health problems faced by children and adolescents, a broad array of health services must be brought into the system of care. Some of the types of health services that should be included in a system of care are described below, beginning with education and prevention and ranging to long-term care.

HEALTH EDUCATION AND PREVENTION

The best long-range strategy to promote good health is a strong program to prevent illness. A major part of such a program is health education, taking place in the home and in the schools. Unfortunately, there is great variability in the availability and quality of health education programs in the schools, and also in the extent to which parents teach and model good health practices. There is also inconsistency in the scope of health education efforts. Some programs, conducted not only in schools but also in youth organizations, are directed exclusively at physical health problems. Other programs more broadly aim at issues of promotion of positive mental health, education regarding family life and sex education and avoidance of reliance on alcohol and drugs.

Recent years have seen increased emphasis on such factors as sound diet and exercise programs for the prevention of health problems. There have also been increased efforts to use educational and media approaches to prevent health problems such as smoking and alcohol and drug abuse, and, to some extent, pregnancy.

SCREENING AND ASSESSMENT

Screening and assessment services are designed to promote early identification of potential health problems. One of the largest of the screening programs is the federally-funded Early Periodic Screening and Diagnostic Testing (EPSDT) program designed for preschool children from low income families.

Routine health screening and assessment can take place in many other ways as well. Typically, assessment begins right after birth at the hospital and often is incorporated into preschool programs. Health screening, for example, is an important part of Headstart efforts. Screening also takes place when children enter the public schools, although such screening is often limited to testing for hearing, vision and speech. Comprehensive diagnostic assessments are often provided through specialized health care facilities such as the Georgetown University Child Development Center.

Placement in a special program presents an opportune time for health screening. Often, children receive health assessments upon placement in special programs for emotionally disturbed youngsters or in out-of-home situations such as foster homes, group homes or residential treatment centers. Screening is particularly important for youngsters from low income families who may not have had access to comprehensive health and dental services throughout their lives.

The identification and treatment of physical health problems can contribute to significant changes in the overall emotional and behavioral functioning of youngsters. For example, for a child to have a dental problem that goes untreated and becomes a source of teasing from peers can be devastating, and the improvement resulting from treatment for the dental problem can be significant. The provision of such screening and assessment to identify problem areas is critical, and again often involves collaboration between multiple agencies.

A development that has attracted considerable attention has been the recent efforts to develop school-based health clinics, particularly targeted at adolescents (Dryfoos, 1985; Edwards, Steinman, Arnold & Hakanson, 1980; and Kirby, 1985). Such clinics are intended to make health services more accessible to youngsters, and play an important role in health screening and assessment as well as in health education and primary care services. As of early 1986, there were 43 school-based clinics operating in 23 communities nationwide. Although the specific services offered by such clinics vary, they typically provide such services as examinations, immunizations, sports physicals, nutrition education, substance abuse programs, laboratory screenings, family planning services and prenatal and postpartum care (Nixon & Whiteford, 1986). School-based health clinics have been shown to be well-utilized by adolescents, and to have an effect on reducing the rate of adolescent pregnancy. They typically involve collaborative efforts of a health agency and a school system. The family planning activities of such clinics have created considerable controversy in some communities, overshadowing the benefits that can be provided in this and other areas.

PRIMARY CARE

Primary care involves comprehensive health examinations by physicians at regular time periods during a youngster's growth and development and follow-up care for any identified health problems. Primary care also includes the routine medical care needed by all children and adolescents to treat illnesses and other medical problems that inevitably arise. Such care is critical to preventing health problems and to the early identification and treatment of health problems. Primary care can be provided through a wide variety of health practitioners and facilities. While pediatricians and family practitioners are most commonly associated with primary health care for children, specialists in adolescent medicine are playing a growing role in providing such health services for adolescents.

The role of the physician in providing primary care has been gradually changing over the years. As medical advances have made possible the prevention and control of more illnesses, there has been a trend for pediatricians and other providers to venture beyond physical health and to expand their focus to include general developmental issues. These developmental issues include the intellectual, social and emotional development of the child.

As a result of this expanded focus, primary care may provide a vehicle for parents to ask questions and receive guidance about all areas of their child's development. The range of knowledge required of physicians has greatly expanded, and there remains considerable variability in the extent to which they take a more general developmental approach as opposed to a more restricted medical approach.

Primary care also encompasses vision and hearing care as well as basic preventive dental care. Ideally, children should begin receiving dental check-ups and cleanings at age three, and should continue to receive such services on an ongoing basis.

For adolescents, a range of additional primary health care services become critical. Because of the extraordinarily high rates of teen pregnancy, family planning services as well as pregnancy testing and counseling cannot be neglected. Approximately half a million teenagers became pregnant and gave birth in 1983, with many receiving late or no prenatal care (Children's Defense Fund, 1986). Thus, prenatal and postpartum care are also needed health services for adolescents. Screening and treatment of sexually transmitted diseases should also become a routine part of the primary health care services provided to adolescents. The failure to address the reproductive health needs of adolescents exposes these youth to long-term physical and emotional hazards (Wientzen & Benton, 1983).

In addition to reproductive health services, screening and treatment of eating disorders and alcohol and drug abuse are also essential primary care health services. Many physicians may not be aware of or comfortable dealing with the special health concerns of adolescents. For this reason, adolescent medicine specialists or practitioners who are familiar with adolescent problems should be involved in the system of care where possible. In addition, other providers within the system of care should be attuned to the special health needs of adolescents.

ACUTE CARE

An important part of any system of services for children and adolescents must be good acute care services for those cases where children are injured or become seriously ill. The importance of acute care services becomes apparent when the rate of accidents among youngsters is considered. In the adolescent age group, accidents claim more lives than all other causes of death combined (Stone, 1983). Accidents may involve motor vehicles, drowning, firearms and poisoning as well as accidents associated with sports and other recreational activities.

Services for accidents and acute illnesses are generally provided on an outpatient basis, but inpatient services must also be available for particularly severe situations. Such inpatient services are generally provided on specialized pediatric units of hospitals, or even within specialized children's hospitals. These specialty units and hospitals are designed not only to tend to the medical needs of the child, but to be more responsive to the psychological needs both of the child and the family.

One of the most often overlooked acute care services is detoxification. Drug and alcohol abuse among adolescents is pervasive in contemporary society. As serious alcohol and drug abuse problems are detected, programs and facilities for detoxification and initiation of treatment are needed. While some youngsters may respond to an ambulatory detoxification and treatment program, others require a

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hospital or residential setting that provides medical management of the detoxification as well as counseling and other mental health services.

The availability of good acute care services (both medical and dental) is critical for the effective delivery of out-of-home services to youngsters. Particularly in group living situations, it becomes important that illnesses be treated as rapidly and effectively as possible, lest they spread to other youngsters in the residential setting. Given the proclivity of children for vigorous physical activity and the frequency of injury, good acute care services are essential. Except for very large residential facilities or hospitals, acute care is typically provided by formal or informal agreement between the agency and local physicians, dentists, hospitals and emergency centers.

LONG-TERM CARE

Although children are typically not considered to be in need of long-term medical care, there are situations in which such care is needed. There has been increasing recognition in recent years that children with chronic illnesses may be at special risk for the development of emotional problems because of the stress created by the illness. The stress, of course, is not restricted to the children but includes parents and siblings as well. Collaborative efforts between physical health and mental health experts have developed both to try to prevent these problems and to treat them as rapidly and effectively as possible.

Children whose physical health problems are of moderate duration, e.g. six months, typically require specialized services from schools as well. These services may either be provided directly in the hospital or in the home. At the same time as the special educational services are being provided, it becomes important to be sensitive to the emotional needs of the child and family.

Mental health professionals may require special training to work with children who have long-lasting physical health problems such as hearing and vision impairment and orthopedic and muscular problems. In particular, communication with severely hearing impaired children can be a special problem requiring very specialized treatment programs. With certain low incidence problems, such as hearing impairment combined with emotional disturbance, it may not be feasible to develop community-based services. The degree of special training required for treatment and the low incidence may indicate the advisability of providing the service in one or two centralized locations within a state.

Children with special needs of this sort have tended to be underserved by mental health professionals. There is increased recognition, however, that more attention must be devoted to children with multiple problems including long-standing physical problems and developmental deficiencies.

DIMENSION 5. VOCATIONAL SERVICES

One of the most neglected dimensions within an overall system of care for emotionally disturbed children is vocational services, shown on Table 5. While employment is an essential key to successful integration into community life, only one-third of all youth with disabilities graduates to a job or some form of advanced education (National Council on the Handicapped, 1986). According to the National Council on the Handicapped, most school systems in this country do not guide disabled youth into

TABLE 6

DIMENSION 5: VOCATIONAL SERVICES

CAREER EDUCATION

VOCATIONAL ASSESSMENT

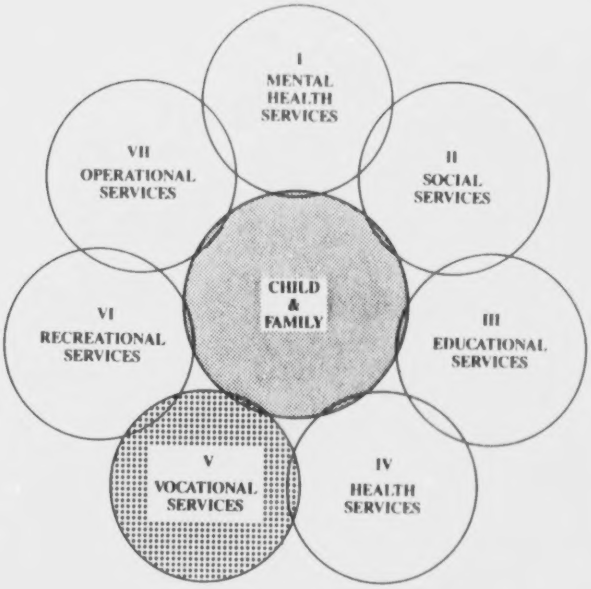
JOB SURVIVAL SKILLS TRAINING

VOCATIONAL SKILLS TRAINING

WORK EXPERIENCES

JOB FINDING, PLACEMENT & RETENTION SERVICES

SHELTERED EMPLOYMENT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II
SOCIAL
SERVICES
CHILD
&
FAMILY
VI
RECREATIONAL
SERVICES
III
EDUCATIONAL
SERVICES
V
VOCATIONAL
SERVICES
IV
HEALTH
SERVICES

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employment opportunities. The lack of systematic vocational services is blamed, in part, for the continued high unemployment rate among persons with disabilities. Without a strong vocational dimension, the system of care will fail to prepare emotionally disturbed youngsters for the transition to employment.

The importance of vocational services has been emphasized recently by the Office of Special Education and Rehabilitative Services (OSERS) of the U.S. Department of Education. OSERS has elevated the entire area of transition from education to work for handicapped youngsters to a top priority (Will, 1984). In so doing, they have created a transitional model that recognizes that some students require special services, either on a relatively brief, time-limited basis or for an extended period of time in order to successfully make the transition to the world of work.

To improve vocational services for youth with disabilities, the Carl Perkins Vocational Education Act (P.L. 98-524) was passed in 1985. The legislation is designed to assist states to develop and improve vocational education programs with a special focus on handicapped students. States are required to develop plans which assess the needs of special groups for access to vocational education and vocational services, and describe how the needs of disabled students will be met. This legislation can potentially have a substantial impact on the vocational services provided to emotionally disturbed youngsters.

In the vocational arena, there are three general classes of skills that are essential for making the transition from school to work (Friedman, 1984b). These are job finding and placement skills; the social and interpersonal skills needed for job retention; and specific vocational-technical skills. In addition, environmental supports and, often, mental health treatment are needed by youngsters with emotional problems to make this transition. The range of vocational services that are needed within the system of care are briefly described below, and are listed on Table 6.

CAREER EDUCATION

Career education involves implementing specialized educational curricula designed to introduce and familiarize students with the world of work. Career education programs cover types of careers, considerations in selecting a career, skills and attitudes needed for success in a career, and expectations of both employers and employees.

Career education can begin in the elementary grades and continue through secondary levels. While it is not focused on teaching actual vocational skills, it can lay an important attitudinal and knowledge base for subsequent vocational training. Career education represents a part of the curriculum that is highly relevant for all students, including those with emotional problems.

VOCATIONAL ASSESSMENT

Vocational assessment involves a systematic process for determining an individual's aptitudes, interests, level of functioning and readiness for employment. Assessment may be done through a formalized process, or may be accomplished less formally through a variety of other activities. Accurate and complete assessment is essential for emotionally disturbed adolescents who face the impending transition from school to the work force. One aspect of vocational assessment examines the aptitudes of the individual. This is typically done through administration of a battery of tests requiring a variety of motor and cognitive skills. The battery is designed to provide guidance about the types of vocations that an individual may be suited for in terms of their abilities.

A second aspect of assessment focuses on the interests of an individual. This type of assessment also includes the administration of a test battery, but the goal is to determine the types of activities that the individual most likes to do for purposes of matching interests with particular careers.

A third type of vocational assessment is perhaps the most critical for severely emotionally disturbed youth. This involves assessment of job survival or work adjustment skills. These skills are often more critical than technical skills in both obtaining and retaining employment. Included are such items as appearance, promptness, attention span, work habits, and perhaps most important, social and interpersonal skills.

Assessment in these areas determines a youngster's "job readiness," and indicates the types of interventions and experiences that will be necessary to prepare for employment. Based on this assessment, a youngster might participate in a job survival skills training program or in other vocational experiences prior to seeking an actual job placement.

Vocational assessment, also called "work evaluation," can be done within special school programs, in specialized rehabilitation settings, or through counseling professionals who have developed specific expertise in this area. One of the most frequent sources of such assessments for individuals with handicaps is the state vocational rehabilitation agency.

JOB SURVIVAL SKILLS TRAINING

Job survival skills include such areas as the social and interpersonal skills needed for interacting appropriately with peers and supervisors in a work setting, for dealing with correction and criticism from supervisors, for requesting assistance when needed, for dealing with anger and frustration in an appropriate manner, and for maintaining a consistent schedule. It is essential that youngsters master these skills if they are to avoid the cycle of getting jobs, holding them for a brief period of time, and being fired.

Unfortunately, there are not many training programs in job survival skills that have been developed specifically for youngsters with emotional problems. The types of skills included in special education curricula, for example, as Wehman and Pentecost (1983) point out, "all too often hold no close relationship with the competencies necessary for vocational independence." Given the emphasis being placed by OSERS on the transition from school to work, it is expected that there will be increased efforts to develop curricula in school systems that are relevant for the demands of employment situations.

Schools are the primary and perhaps most logical site for job survival skills training. However, such training can also take place within rehabilitation centers and mental health agencies. Training can be provided both on a group and an individual basis. Too often, the emphasis in the vocational area has been on helping individuals to train for and find employment, with relatively little emphasis on the skills needed to maintain the job.

VOCATIONAL SKILLS TRAINING

Vocational skills training more directly focuses on the technical aspects of particular jobs. This can involve anything from training in the high technology fields such as computers, or training for more routine work such as washing dishes or pumping gas.

Most vocational skills training takes place in school settings. However, a major problem is that such training has typically not been available to youngsters with serious emotional problems. Presently, all states are required by the Federal government to set aside 10 percent of their vocational education funds specifically to serve the handicapped. Unfortunately, despite this requirement there has been relatively little attention paid to the needs of severely emotionally disturbed children. Closer cooperation is critically needed between vocational educators and special educators to make vocational training available to youngsters with emotional problems.

Some specialized vocational training programs for severely emotionally disturbed youngsters are in existence. For example, the Brewster Tech program in Hillsborough County, Florida (Colucci, 1986) provides day treatment for severely emotionally disturbed children in a vocational training setting. Such a combination of services can be extremely beneficial for older adolescents.

The co-location of a day treatment or special education program with a vocational school can also be advantageous. Because of the high cost of equipment for vocational training and the need for instructors with specialized skills, it is often difficult and expensive for vocational training units to be placed at regular special education or mental health treatment sites. Creative co-location and programming by mental health, special education and vocational education agencies is needed to overcome some of the financial and system obstacles to providing vocational training for severely emotionally disturbed youngsters.

WORK EXPERIENCES

Some day treatment and residential programs provide limited vocational training and work experience for youngsters. They may set up particular "shops" or learning stations to provide training and to diversify the educational experience of youngsters. They may also provide work experiences both within the program and in the community. Such work experiences can be useful both from a training standpoint and also for purposes of motivation. The opportunity to obtain salaried work, even if it is at a relatively low salary and for just a few hours a week, can be a powerful motivator and can help a youngster to develop more of an adult identity.

These types of work experiences are similar to the concept of prevocational work experience and transitional employment used in many programs for adults with mental illness. The concept of prevocational work experience is most commonly associated with the psychosocial rehabilitation model. Programs organize work experience into a variety of units such as clerical, food service, maintenance, education, video, etc. By performing real tasks, individuals develop vocational skills, basic job readiness skills and confidence.

Transitional employment involves job slots in the community which are available to individuals on a part-time, temporary basis. An individual might remain in a transitional employment position for three to nine months, and might have three or more different placements over time. Transitional employment serves as a bridge between training and competitive employment, allowing individuals to learn vocational and work adjustment skills and to gain confidence in a normal work environment. Adaptations of both prevocational and transitional work may be needed for severely emotionally disturbed adolescents in preparation for vocational independence.

In addition to the schools, vocational rehabilitation agencies also provide vocational skill training. Typically, this is done by providing the funding necessary for individuals to secure such training from private schools and training organizations.

JOB FINDING, PLACEMENT AND RETENTION SERVICES

These services are directed at helping emotionally disturbed youngsters to locate job opportunities, successfully apply for jobs and to retain employment over time. Services may involve teaching job-seeking and interviewing skills to youngsters or providing direct assistance in identifying, obtaining and keeping jobs.

One of the more innovative approaches to assisting individuals to find jobs has been the Job Club, a model developed by Azrin (Azrin & Besalel, 1980). This is a group-oriented, highly structured approach designed to assist individuals in looking through ads, making initial contacts with potential employers and going on interviews. The program has proven effective with unemployed individuals, and has promise for older adolescents with emotional problems.

The Job Club approach, with its strong group support component, also has the potential for assisting in job retention. Particularly for young people with emotional problems, job situations often prove frustrating and stressful. One of the responses to the frustrations is often to leave the job. Group support procedures can assist youngsters to deal constructively with the frustrations and to continue with their employment.

The National Research Center on Vocational Education (McKinney, 1983) has done preliminary work on the use of volunteers to assist handicapped youngsters to find and keep employment. Such a model may also be applicable for severely emotionally disturbed youngsters both in finding and retaining positions. Severely emotionally disturbed youngsters, who often show poor impulse control, have a difficult time responding to correction, and may have a pattern of challenging individuals in authority. Volunteers may play a key role by providing ongoing support to the youngster and to the employer. Such environmental supports can be critical for securing and retaining employment.

In addition to job finding and placement, some mental health and vocational agencies engage in job development activities. This involves working with employers in the community to encourage them to provide jobs for emotionally disturbed adolescents. Counselors work with the youngsters and employers throughout the job development and placement process. Counselors may also provide follow-along services, remaining available to respond to crises or problems which may occur on the job as well as to provide ongoing support.

SHELTERED EMPLOYMENT

Sheltered employment is a term used to describe employment in settings with high levels of support and supervision. Sheltered workshops and similar programs offer handicapped individuals the opportunity to engage in productive work activities within a supportive environment.

Sheltered work may be used as a training or transitional experience. In this case, individuals have the opportunity to learn the needed job survival or work adjustment skills as well as specific vocational skills. They earn a salary while doing so, and are in a setting which addresses mental health as well as vocational needs.

Some individuals are unable to make the eventual transition to competitive employment. In these cases, sheltered employment might be a longer-term alternative which allows an individual to be productive and to make a contribution in accordance with his or her abilities.

The field of vocational services for severely emotionally disturbed youth is still in its infancy despite the growing recognition of its importance. There is a critical need for effective models for working with severely emotionally disturbed youth to prepare them for vocational independence.

DIMENSION 6: RECREATIONAL SERVICES

Another dimension of the system of care for severely emotionally disturbed children is recreational services, shown on Table 7. Play and recreation are critically important in the development of a child. However, in the case of an emotionally disturbed child, isolation from peers is the norm. Whether because of their own behavior or because of the attitudes of their peers, severely emotionally disturbed children are often not included in the play associated with healthy, normal development. Consequently, these children often miss important opportunities for growth and their handicap may be compounded.

Play and recreation activities can serve several functions for the severely emotionally disturbed child. The child can learn new skills that build self-confidence and enhance self-image. The opportunity is provided for the development of important social skills such as cooperation and good sportsmanship. Appropriate recreational activities can allow a child to form a positive relationship with a significant other outside the family such as a coach. Finally, recreational activities can serve as a form of respite for the family (Fredericks, 1980).

There are two possible approaches to providing recreational activities to severely emotionally disturbed children. First, recreational activities may be arranged specifically and exclusively for severely emotionally disturbed children. These activities or programs may have "therapeutic" objectives as well as purely recreational ones. Such activities may take place in the context of other programs and services, or separate recreational programs and events may be organized for emotionally disturbed youngsters. Recreational activities may be led by specially trained recreational therapists or by other professional or paraprofessional staff, volunteers or parents.

As an alternative, efforts may be devoted to gaining access for emotionally disturbed children to existing recreational programs and activities. While cost can be a barrier, many recreational activities can be provided inexpensively through the use of volunteers. The following description highlights several types of recreational activities that are currently operating for severely emotionally disturbed children.

TABLE 7

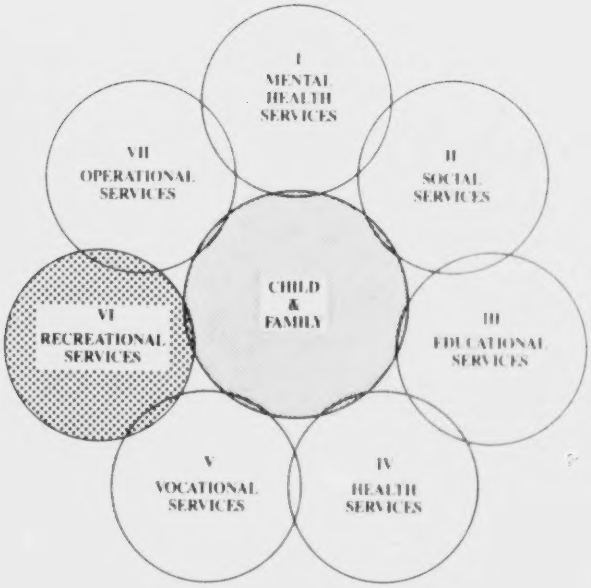
DIMENSION 6: RECREATIONAL SERVICES

RELATIONSHIPS WITH SIGNIFICANT OTHERS

AFTER SCHOOL PROGRAMS

SUMMER CAMPS

SPECIAL RECREATIONAL PROJECTS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RECREATIONAL
SERVICES
VII
OPERATIONAL
SERVICES
CHILD
&
FAMILY

RELATIONSHIPS WITH SIGNIFICANT OTHERS

Several recreational programs have as their goal the establishment of a positive relationship between a child and a caring adult. One of the most widely known of these types of programs is The Big Brothers/Big Sisters Program. While the programs are characterized as recreational, the goals of these programs extend beyond recreation to include overall social functioning.

The essence of these programs is a match between a child in need of adult companionship and an adult who has given a commitment to become involved with the child. The commitment of the volunteer is extremely important, because an inconsistent adult can simply reinforce the child's lack of trust in adults. The adults are volunteers, and are expected to spend time with the child in recreational activities of any type. Volunteers are not expected to buy things for the child. If an activity has an admission fee, for example, the cost is the responsibility of the parent. Frequently, charities such as the United Way support such programs. Other sources of "significant others" are church groups and service organizations.

While these programs were originally developed to meet the needs of children in single parent homes, they have taken on a broader scope and increasingly serve handicapped children, including those with emotional disturbances.

AFTER SCHOOL PROGRAMS

Many communities offer after school recreational programs for children of working parents. With some adaptation, these programs can be a valuable resource for severely emotionally disturbed children. Primarily, the staff require training in dealing with severely emotionally disturbed children, especially in the areas of discipline and peer relations. Program needs are more demanding in that severely emotionally disturbed youngsters are often not able to tolerate the large amounts of unstructured time typically involved in after school programs.

After school programs can serve two major functions for the severely emotionally disturbed child. First, tutoring in academic areas can be beneficial to a child. Many severely emotionally disturbed children are behind in their academics. After school tutoring and help with homework can very often make the difference between success and failure for a child. Success in school, of course, has a major bearing on the child's total emotional well-being. Secondly, such programs offer a supervised environment for the development of social skills. The games and activities conducted under adult supervision can offer the child some tangible social successes, and can contribute to positive behavior change.

After school programs have typically been administered by church groups, Y's, and community action agencies. There is usually a sliding scale fee schedule for services. If cost is a problem, such programs are an excellent use for "wrap around" service funds if available.

The respite function offered to the family by after school programs is significant. The time before supper is one of those difficult periods in a family's day, and many crisis situations can be avoided by having a severely emotionally disturbed child constructively engaged while the rest of the family is regrouping from the demands of the day.

SUMMER CAMPS

A more intensive therapeutic recreation experience is that offered by special camps. These programs are available during the summer months and may be either residential or day camps. While camps provide valuable therapeutic interventions, they also serve the important function of providing respite for parents.

Most of the camp programs serve children with all types of handicaps, although some are exclusively for emotionally disturbed children. Many of these camps are administered by a college or university, while others are operated by residential schools such as the Devereaux Foundation or The Brown School. Charitable organizations, such as the Easter Seal Society, may also operate camps. In some instances, the state or local Mental Health Association may also operate summer camp programs for emotionally disturbed children.

The programs at special camps are comprehensive and generally continue with the concept of an individual plan for each child. An example of such a program is Camp HELP operated by Jacksonville University in Alabama. The camp views therapeutic play as contributing to the positive development of the child. The staff serves as significant others in forming close relationships and in affecting the child's behavior (Rosewall, 1983).

Project PLAY, an overnight camp for handicapped children (including emotionally disturbed children) in Nebraska, views recreation as respite. It is a cooperative venture of the University of Nebraska, the Hattie B. Monroe Foundation and the Meyers Children's Rehabilitation Institute. This program not only strengthens the skills and behavior of the child, but also improves the quality and quantity of the family's social interaction through supplying respite care, a family support network and family counseling and training (Robinson and Crawford, 1985). Another example of a summer camp for emotionally disturbed is provided by Daybreak in Vermont. Run by the Vermont Association for Mental Health, the camp provides a two-week camp experience for children as well as respite for parents.

A summer camp in Birmingham, Alabama provides an example of the use of existing recreational programs for emotionally disturbed children in combination with specialized activities. The Mental Health Association of Jefferson County, Alabama sponsors a summer day camp for emotionally disturbed children from eight to 12 years of age. The program was developed in response to requests from parents who could find no constructive summer activities for their emotionally disturbed children. The children participate in some of the activities of a regular YWCA day camp and also attend specialized sessions and activities geared to address their special needs (Alabama CASSP, 1986).

SPECIAL RECREATIONAL PROJECTS

Special recreational projects are often undertaken by service organizations in the community to help problem children. One example of a special project is the horseback riding for troubled youth conducted by the 4H Club. This program attempts to supply fun as well as instill responsibility for taking care of an animal. For many children the special relationship that develops through taking care of a horse becomes a very powerful self-concept builder. The 4H members volunteer their time and donate the use of their horses for these programs. A minimum amount of coordination is necessary, and the major cost is usually insurance.

Thus, there are a wide variety of recreational activities that can have a significant therapeutic effect on severely emotionally disturbed children as well as affording opportunities for fun and enjoyment.

DIMENSION 7: OPERATIONAL SERVICES

This final dimension includes a range of support services that can make the difference between an effective and an ineffective system of care for severely emotionally disturbed youth, but do not fall into a specific category. Instead, they tend to cross the boundaries between different types of services. They are called "operational services" because of their importance to the overall effective operation of the system. As shown on Table 8, the services included in this dimension are case management, self-help and support groups, advocacy, transportation, legal services and volunteer programs.

CASE MANAGEMENT

In a recent article describing the changes that have taken place in the North Carolina system for children, Behar (1985) calls case management "perhaps the most essential unifying factor in service delivery." This indicates the important role that case management can play in a system of service, a role that has been increasingly recognized in recent years but has only been operationalized in a few states. In those states and communities in which case management has been implemented, it has typically been in a limited way.

Case management serves youngsters involved in both residential and nonresidential programs. It involves brokering services for individual youngsters, advocacy on their behalf, insuring that an adequate treatment plan is developed and is being implemented, reviewing client progress and coordinating services. Case management involves aggressive outreach to the child and family and working with them and with numerous community agencies and resources to ensure that all needed services and supports are in place.

Behar (1985) indicates that in North Carolina, "Case management, in its most positive sense, has emerged as: (a) the element of planning and coordinating that has combined the workings of all agencies concerned with the child, (b) the energizing factor that has propelled the service plan into the reality of service delivery, and (c) the case advocacy strength that has sustained a commitment to each child and an optimism about each child's capacity to change."

Part of what is described as case management is services that skilled and committed clinicians have often provided. In fact, to emphasize the clinical nature of the activities, one program in Florida specifically calls their services "clinical case management" (Roberts, Mayo, Alberts & Broskowski, 1986). However, particularly for children with serious problems and multiple needs, the requirements for case management are extensive and beyond the capability of clinicians who are at the same time providing direct treatment. In addition, case managers who are not also the primary treatment agent are in a position to more independently review the progress of their clients and to more effectively advocate on their behalf.

In discussing these issues, Behar (1985) indicates that "initially many clinicians responsible for the direct treatment of clients believed that the case managers represented threats to their relationships with their clients, and/or that they were

TABLE 8

DIMENSION 7: OPERATIONAL SERVICES

CASE MANAGEMENT

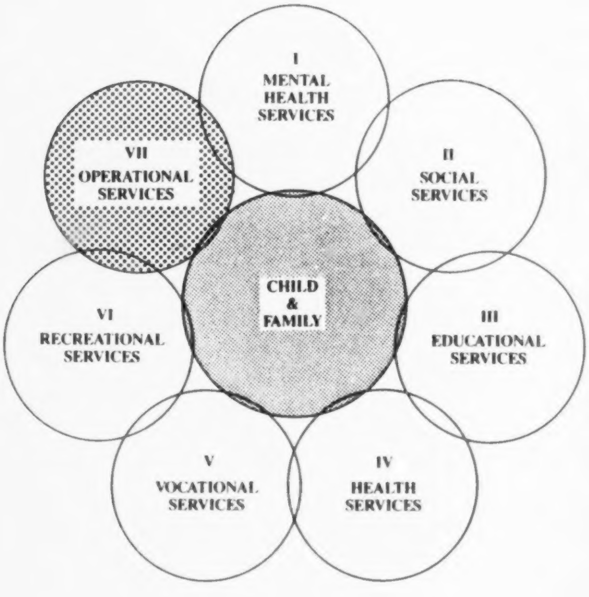
SELF-HELP & SUPPORT GROUPS

ADVOCACY

TRANSPORTATION

LEGAL SERVICES

VOLUNTEER PROGRAMS


I
MENTAL
HEALTH
SERVICES
VII
OPERATIONAL
SERVICES
II
SOCIAL
SERVICES
CHILD
&
FAMILY
VI
RECREATIONAL
SERVICES
III
EDUCATIONAL
SERVICES
V
VOCATIONAL
SERVICES
IV
HEALTH
SERVICES

capable of merging the case management function with the treatment function. At this point, it appears that therapists/clinicians generally do not see the case managers as threats to their role with the clients. Regarding the latter point, certainly some clinicians can and do merge these functions, but most believe that the functions are better separated."

Not only is it desirable that case management and direct treatment be separated for youngsters with multiple and serious problems, but it is also important that case managers be placed in a position that accords them both considerable independence and influence within the overall system. Without such a placement, the ability of case managers to effectively advocate for clients, to coordinate and broker services, and to monitor treatment plans and progress becomes limited. If for example, a case manager is part of a mental health agency staff and reports to the supervisor of children's services, then that case manager may be restricted in his or her ability to advocate for additional or different services within that agency for the youngster. Further, unless that agency is specifically designated as a "lead" agency, or has some special authority, or the case manager controls some extra resources, then the ability of the case manager to advocate for services in other agencies may be limited.

While case management may be separated from the treatment function, it is essential for the case manager to establish a warm, supportive and collaborative relationship with the child and family. According to Modrcin, Rapp and Chamberlain (1985), the case manager-client relationship represents the "core" of the case management process, ensuring that case management services are not mechanistic, but rather are a highly personal form of helping.

Another important issue with regard to case management relates to the size of caseloads. Often within public agencies, there is the appearance of greater cost-effectiveness if high caseloads are maintained. For example, caseloads of 30 children per worker typically appear to be more economical than caseloads of 10 or 15 children per worker. They also allow more children to be served. It is important to note, however, that effective service for seriously disturbed children often requires intense and very rapid interventions. Additionally, frequent contact with all involved agencies is important to effective service coordination and brokerage. Further, if case management services are not effective, then the costs to the system, frequently in terms of residential placements of youngsters, can be very high.

Given the multiple needs of severely emotionally disturbed children, the seriousness of their problems, the frequency with which crises develop, and the high cost of failure, it is important to keep the caseloads of case managers relatively small. By increasing success rates, small caseloads may actually enhance the cost-effectiveness of the service. Although there are no carefully tested standards with regard to caseload size, it is generally recommended that they be in the range of 10 to 15 cases per worker. In the North Carolina Willie M. program, each case manager has a caseload of 12 to 15 cases (Behar, 1985, 1986).

Additionally, there is increasing recognition of the advantage of having flexible money available to the case manager that can be used on a case by case basis to help individual children. For one child, such money might be used to purchase a special evaluation. A second child may be experiencing severe conflict with his or her parents, and such money could be used to purchase the services of an in-home family counselor much like in the Homebuilders model. A third child may be having an especially difficult time in school, and may need an aide to work with him or her and the school personnel right in the classroom. Sometimes services like these are available, and at other times they are either not available or filled to capacity. With flexible funding controlled by the case manager, it becomes possible to purchase these specialized services as needed. Other uses of flexible monies might be for extra clothing, or to pay the registration fee for a team or club for a child.

Such flexibility is an important part of the North Carolina system, and has been built into a program in Florida as well (Roberts et al., 1986). In the Florida system, the lead agency has contracted with a mental health agency to not only provide case management but to insure that there is a cadre of well-trained counselors available who can be dispatched on very short notice to work with youngsters and families, if there is a need and if no other services are available.

Another important issue in implementing case management services is determining eligibility for such services. In North Carolina, a unique situation exists because of a court mandate to serve all youngsters who meet the criteria of being a "Willie M." child. All such youngsters who meet the criteria are provided with case management services. In Florida, a formal mechanism exists for agencies to come together to conduct staffings for individuals considered to need public funding for a residential placement. Youngsters who are approved by that committee as needing such placement then become eligible for case management.

Both of these approaches are limited to providing case management services only to those youngsters with the most serious needs. Such an approach can be an effective way of establishing case management services on a limited basis, and can help to reduce the need for residential services. Further steps can then be taken to expand the services to include a broader range of clients. For example, in North Carolina efforts are now being made to make case management available to all youngsters in the mental health system who require more than one service.

In earlier discussions of residential placement, it was noted that one of the important determinants of positive outcomes was the post-discharge placement and services available for the youngster and family. It was also indicated that for many youngsters, there is the special problem of the absence of any viable biological family to return to, creating an even more critical need for careful and creative discharge planning. Case managers can and should play a key role in this discharge planning with regard to living situations, school placements, vocational training and follow-up mental health treatment. The role of case management is especially important if the youngster is returning from a residential placement that is outside of the community to which he or she is returning. The effective use of case management with youngsters in residential treatment may reduce the length of stay, thereby saving money, and at the same time helping to achieve more positive outcomes (Roberts et al., 1986).

An important caution with respect to case management is that despite its apparent benefits, there has not yet been careful research to determine its effectiveness. Such research in fact is very difficult to conduct, because case management services are so closely entwined with the entire system. Behar (1985) points out that, "Case managers cannot do their complex jobs without having a service system available; however it would appear that the service system does not function maximally without the case managers." Despite the difficulties, however, there is clearly a need for research to establish a firm empirical base for the development, expansion and possible modification of case management services. There is a need not only for research on the overall effectiveness of case management services, but also on the relative advantages and disadvantages of particular features of case management such as the type of agency that provides services, caseload sizes and use of flexible funds.

SELF-HELP AND SUPPORT GROUPS

One of the major developments in human services over the past 10 to 20 years has been an enormous increase in the number of self-help and mutual support efforts that have started. These efforts either involve individuals who presently or previously have had a particular problem, or members of their families. They are based on the view that individuals with similar circumstances have the capacity to understand and assist each other, and that the support of other concerned individuals is a great asset in helping to cope with difficulties.

The self-help groups typically provide emotional support and a variety of forms of practical help for dealing with a problem that is common to all members. Some of the longer-standing groups of this sort are Alcoholics Anonymous and Gamblers Anonymous and other self-help groups have formed in areas such as weight loss, bereavement and child abuse. Groups have also developed to provide mutual support and assistance to family members of the individuals with the problems.

In the mental health field, this self-help movement has led to efforts for both clients and family members. In fact, a national organization, the National Alliance for the Mentally Ill, with chapters in most states in the country, has been started by family members in recent years. The rapid growth of these family groups indicates that they are clearly in touch with an important need experienced by many individuals. Self-help groups comprised of adult mental health consumers are rapidly becoming an important force in the mental health field. Consumer groups are now in operation in many states and are rapidly proliferating. A National Mental Health Consumers Association was formed in 1985 as a means of linking the consumer self-help groups around the country. Such self-help groups provide mutual support and advocacy, and are beginning to provide consumer run services as alternatives to the mental health system.

Most of the efforts in the mental health field have focused on adult clients and their families. Self-help efforts in the children's area have tended to deal with problems such as child abuse (e.g., Parents' Anonymous), substance abuse, or physical handicaps or disabilities. A recent national survey identified very few support groups existing exclusively for family members of emotionally disturbed youngsters (Friesen, 1986a). Of 207 parent organizations identified across the country, 15 were primarily for parents of severely emotionally disturbed children. The remaining groups included parents of emotionally disturbed children along with parents concerned about other childhood disabilities. A directory of these parent organizations is in press (Portland State University, 1986).

With increased recognition of the potential value of support groups for family members, there are signs of growth of parent support groups for parents of youngsters with serious emotional problems. Stimulated by the efforts of NIMH, parent groups are expanding and appear to be meeting an important need. A concern with respect to parent support has been that parents would perhaps feel "blamed" or "stigmatized" by having a child with serious emotional problems and would be unwilling to come forward and participate in a support group. Evidence is mounting, however, that parents are not only willing, but anxious for opportunities to come together to share problems and solutions. The response to a newspaper advertisement in Kansas soliciting parents for a support group was very positive (VanDenBerg &

Donner, 1986). Further, activities at the Portland Research and Training Center are aimed at conceptualizing the role of parents as "partners" with professionals in the care and treatment of their youngster, and overcoming the view of parents as the "cause" of their child's problems. These activities include a recent conference for professionals and parents entitled "Families as Allies" (Friesen, 1986b) and an annotated bibliography related to parents of emotionally disturbed children (McManus & Friesen, 1986).

There are few, if any, self-help efforts for emotionally disturbed youngsters themselves. There is the possibility, however, that consumer self-help models will prove to be as applicable for youngsters as for adults, particularly for older adolescents. There is an important need for further efforts in the self-help area for youngsters, as well as continued efforts to promote the development of support groups for parents.

ADVOCACY

Advocacy refers to efforts to develop and secure the needed resources and services for accomplishing particular goals. Knitzer (1984) describes advocacy as "efforts to improve the quality of services, and strengthen the rights and protections accorded to children." As such, advocacy can play a critical role in the system of care.

The importance of advocacy was emphasized in a recent report that focused on services for the seriously mentally ill in different states across the country. Referring specifically to consumer groups, one of the most potent types of advocacy groups, Torrey and Wolfe (1986) indicate that, "Consumer groups are one of the two most important factors in improving services. The stronger the consumer groups are, the more likely services are to improve."

Although the study by Torrey and Wolfe focused primarily on services for adults, advocacy efforts appear to be equally important for children and adolescents. In recognition of this, one the major recommendations of the Joint Commission on the Mental Health of Children (1969) was that a national system of child advocacy be developed to secure the availability of a wide range of services for children of all ages. However, as Knitzer (1982) pointed out in her study of services for children across the country, "Despite the crying need for reform, advocacy on behalf of disturbed children is scarce, whether for individual children or to change public policies affecting groups of children."

There are two basic types of advocacy. The first is "case" advocacy, or advocacy on behalf of the needs of individual children. Effective case advocates must be knowledgeable about the workings of the service systems which serve children, and must be skilled in making these systems more responsive to the needs of individual children. As Knitzer (1984) indicates, "advocates must be knowledgeable about the relevant statutes as well as any administrative regulations, and frequently about service programs as well. Armed with such information, case advocates are in a position to apply basic advocacy tools such as persuasion or negotiation, and ultimately, if all else fails, litigation." Case managers can play a major role in case advocacy, as can other professionals and citizen advocates interested in the needs of individual children.

While the primary goal of the case advocate is to insure that an individual child receives the services he or she needs, the case advocate also strives to produce enduring systems change in the process. Young (1985) emphasizes that in advocating for an individual child, an attempt is also being made to produce a more responsive and effective overall system.

The second type of advocacy is "class" advocacy, or advocacy on behalf of a group of individuals. Class advocacy, if successful, can have a greater impact than case advocacy because it can produce changes that affect more children (Knitzer, 1984). Class advocacy is typically a lengthy process that requires not only considerable knowledge and skill, but also enormous persistence.

There are a variety of class advocacy strategies including such activities as education, monitoring the implementation of policies, preparation of studies and reports, budget analysis, meeting with policymakers, coalition building, legislative lobbying and legal action. Within recent years, increased class advocacy efforts at state and national levels have focused on tracking expenditures for children's services and insuring that children receive their adequate share of funds. This is particularly important in tight budget times, and also because services for emotionally disturbed children are embedded in a system that has a strong adult focus. For example, a recent analysis indicated that children's mental health budgets average about 15 percent of the overall mental health budgets of states, despite the fact that children constitute about 25 percent of the population (Update, 1985c; NASMHPD, 1985). This analysis further showed that in many states, it was not possible to determine the percentage of mental health funds that went to serve children.

There have been a number of problems that have diminished advocacy efforts on behalf of emotionally disturbed children. One problem has been that children's emotional and behavioral problems are often poorly understood, particularly because the overt signs of the problems are often noncompliant and aggressive behavior. In talking specifically about services in the school systems, Eaves (1982) points out that, "Most children diagnosed as emotionally disturbed exhibit behavior that engenders hostility rather than sympathy. Consequently, there has never been a groundswell of support for school programs designed to serve these youth."

Further, as already indicated, parents of children who are emotionally disturbed have typically not been organized. This reflects the stigma that is attached to mental health problems, and also reflects the fact that many severely emotionally disturbed children come from families where the stress level is so high that most of the energy in the family goes to coping with day-to-day problems rather than to advocacy. The absence of strong "consumer" advocacy has made the task of improving services all the more difficult.

While parent advocacy for emotionally disturbed children is in its infancy, there are places in the country where parent advocacy groups are growing. The Parents Involved Network (PIN) Program of the Mental Health Association of Southeastern Pennsylvania is an example of such a parent advocacy effort as well as the Child Advocacy Project of the Alliance for the Mentally Ill of Wisconsin and REACH through the Mental Health Association of North Carolina.

The Mental Health Association and the more recently formed National Alliance for the Mentally Ill are beginning to focus more attention on the need to improve services for children. These are key groups that until recently have been oriented towards advocacy on behalf of adults, but are currently beginning to embrace children's issues. State and community level efforts to promote parent advocacy are evidenced by the special projects noted above. Further, several state Mental Health Association chapters have established children as their top priority. The Indiana Mental Health

Association has a children's mental health staff person and a registered lobbyist on staff to address children's issues. Children's issues are beginning to emerge at the national level as well. For example, the theme of the 1986 annual conference of the National Mental Health Association is services for children.

Professional and provider associations are also involved in advocating for improved services for emotionally disturbed children. The National Consortium for Child Mental Health Services is composed of national professional, provider and consumer organizations and meets quarterly to exchange information and ideas on public policy and programs serving mentally ill children and adolescents. The member organizations include the National Association of State Mental Health Program Directors, the National Council of Community Mental Health Centers, the American Psychiatric Association, the American Psychological Association, the National Association of School Psychologists, the Child Welfare League, the National Mental Health Association and many other groups.

Many states have child advocacy groups that focus on multiple issues such as child abuse and neglect, day care, education, delinquency, substance abuse and teenage pregnancy. The mental health needs of children are but one part of the agenda of these organizations, and have typically not been a high priority. Many of these organizations have now come together to form a national organization, the Association of Child Advocates with headquarters in Cleveland, Ohio. The needs of emotionally disturbed children are gaining recognition as an important issue. On a national basis, the Children's Defense Fund is a multi-issue child advocacy group which produced the very significant national study of services for emotionally disturbed children that was conducted by Knitzer (1982) and called Unclaimed Children.

Other groups have shown interest in issues relating to emotional disturbance in children. For example, the Florida Council for Community Mental Health launched a multifaceted effort called "Bring Our Children Home," which was designed to bring emotionally disturbed children back from out-of-state placements (Zeigler, 1986). In some communities, parent-teacher associations, church groups, civic groups, social action groups and business organizations have advocated on behalf of emotionally disturbed children. These groups all have the potential of playing important roles in strengthening services.

Efforts to advocate for improved services are beginning to take the form of coalitions of organizations. The Northeast Ohio Coalition was perhaps one of first to focus specifically on the needs of emotionally disturbed children (Young, 1985). This group was organized in 1980 in response to a threatened cut in funding for children's mental health services, and from that starting point has focused on a variety of issues. The basic objectives of this coalition are to:

- Promote greater availability of, and improvements in, mental health care for children and families when needed and where needed in Northeastern Ohio.
- Advocate for changes to make planning and funding systems better serve the needs of children and youth.
- Assist cooperative work among agencies responsive to the human service needs of children and families.
- Promote public awareness of children's mental health problems, their causes and required solutions.

Such coalitions have the advantage of added strength because of the different organizations involved, and they have the potential of exercising considerable influence over policies and services.

State protection and advocacy systems can play an important role in both case and class advocacy for severely emotionally disturbed children and youth. The Developmental Disabilities Act of 1984 (P.L. 98-527) requires states to develop systems to protect and advocate for the rights of the handicapped. Such systems are independent of any service providing agency, and have the authority to provide legal and administrative remedies to the denial of services or other problems or abuses related to the service delivery system. The Protection and Advocacy Act for Mentally Ill Individuals of 1986 (P.L. 99-319) extends protection and advocacy services to the mentally ill to insure that their rights are protected. The Act provides for the establishment of a protection and advocacy program in each state to be administered by the existing protection and advocacy program. The Act authorizes some funding for such protection and advocacy activities, and includes a bill of rights for mentally ill persons.

State protection and advocacy services generally include rights notification, information and referral, complaint investigation, training, consultation and education (Scallet, 1986). Some states are beginning to focus protection and advocacy systems on severely emotionally disturbed children. In South Carolina, for example, the protection and advocacy system was instrumental in the creation of a policy of "no reject - no eject" from the system of services for emotionally disturbed children, guaranteeing that a child will be served once he or she is defined as eligible.

The increased interest in advocacy is one of the more encouraging signs in the children's mental health field in recent years. A key issue affecting the degree to which effective systems of care will be developed is the extent to which strong, persistent and well-targeted advocacy efforts can be developed at the community, state and national levels.

TRANSPORTATION

A familiar finding of needs assessment studies, regardless of the human service area, is that one of the priority needs is for transportation. Even if high quality services exist, children and families may not be able to use them without adequate transportation.

One approach to this problem, as already presented, is to bring services into the home of the youngster and family. While this is critical in some cases, it is also relatively expensive and certain services do not lend themselves to such a home-based approach, e.g., specialized educational and after school services, support groups, recreation, vocational training and group activities in general.

Another approach to addressing the problem of transportation is for agencies to set up satellite offices close to heavily populated areas. While this does not eliminate the need for transportation, it does reduce the distance that has to be traveled, and often may place services within walking distance of the clients.

Still another approach, illustrated by school-based health clinics, is to increase accessibility by providing services at a site to which the potential clients will already be coming. This is a promising approach. Certainly, the combining of services at a single site reduces the need for transportation while making it easier for individuals and families to use all services.

Some agencies, in recognition of the seriousness of the problem of transportation, specifically budget to provide such transportation services. This may include the purchase or rental of a van (including a driver) or the allocation of funds to pay either for public transportation or taxi fare when used by clients. Some agencies focus on the recruitment of volunteers as a mechanism to provide transportation. In other instances, agencies negotiate or receive special rates from public (and even private) transportation for their clients.

The transportation problem is important not only because it prevents clients from accessing services, but also because it often ties up the time of professionals who might otherwise be using the time to provide needed services. Further, for youngsters in out-of-home placements, particularly if such placements are not in the youngster's home community, the absence of transportation can be a major obstacle to working with the family and returning the youngster home. Especially in rural areas, the absence of transportation is a major barrier to service delivery.

For the system of care to be effective, the overall problem of service accessibility must be overcome. This is one of many areas in which creative problem solving involving multiple agencies and both the public and private sector may be needed to develop solutions.

LEGAL SERVICES

An effective system of care needs an adequate statutory and legal base as well as procedures to insure that statutes are followed and that client's rights are protected. In most cases, the process of insuring that the client's rights are protected can be accomplished without resorting to the use of legal services. In some cases, however, legal services are very important. Legal services may be obtained from Legal Services Corporation offices, public defenders, private attorneys and from special programs to fulfill this need. For example, some Mental Health Associations have attorneys on staff to provide legal advocacy services for children and families.

Legal services are most important when actions are about to be taken that are either extremely restrictive, involve removal of a child from a home, or are against the wishes of a youngster. Specifically, placement of youngsters in residential settings, their continuation in such settings, and removal of youngsters from their family may be issues warranting legal services to insure the protection of the youngster's rights. Legal services are also needed to ensure due process when a child becomes involved in the juvenile justice system as a result of committing an offense.

Legal services may also be needed when practices of agencies may be harmful or excessive to clients. This may include such actions as the use of extreme punishment, the use of lock-up and other procedures for excessive periods of time, the combining of children with adults in settings in which this may be harmful to the children, and the placement together of groups of youngsters with different problems who should be treated separately.

There are significant roles for legal experts in developing relevant statutes, in applying the statutes on a case by case basis, and in monitoring the application of the statutes on a broad basis. The issues can become extremely complex, particularly since the status of a youngster in a court of law, especially an adolescent, is not always clear. Mental health commitment laws, for example, are inconsistent from state to state in terms of the extent to which adolescents are accorded the same rights as adults or are treated as children.

Other broad legal issues involve insuring that adequate services are available for children and families in need. In cases where adequate services are not available, and nonlegal efforts to secure them have not succeeded, then class action law suits may be initiated. The Willie M. lawsuit in North Carolina (Behar, 1985, 1986) is an example. The lawsuit, Willie M. et al. v. James B. Hunt, Jr. et al. stated "that four minors and 'all others similarly situated' had been denied the appropriate treatment and education that were rightfully theirs under a series of federal and state statutes and the U.S. Constitution." Similar lawsuits seeking either to change the availability of services, or procedures to determine eligibility of services within the educational system include J.G. v. Board of Education of the Rochester City School District (Schneider, 1985), and the Lora Case in New York City (Wood, Johnson, & Jenkins, 1986).

The role of legal services in developing and operating an effective system of service is an evolving one. Legal services are needed to help in the enactment of statutes and in the application of the statutes, in insuring that the rights of children and families are protected, and in advocating for improved and effective services.

Legal services of another type come into play when a youngster breaks the law. Under these circumstances, children and adolescents come into contact with the juvenile justice system. The juvenile justice system is a legally-based, correctional system with a primary role in the control and management of behavior. The juvenile justice system includes juvenile justice agencies (often called youth services agencies) and juvenile and family courts as well as probation departments, correctional facilities and related agencies and programs. While these "legal services" are directed at helping children and families, they are also intended to protect the community and society by responding to dangerous behavior and infractions of the law.

The juvenile justice system serves a variety of youngsters ranging from status offenders or persons in need of supervision to youth who are habitual offenders and those who are violent. There is some debate and disagreement as to precisely what percentage of juvenile offenders can be considered to be emotionally disturbed or mentally disordered (Isaacs, 1985). It is agreed, however, that many juvenile offenders are severely emotionally disturbed, and require the services of the system of care. Juvenile offenders needing such services are heterogeneous, and include those diverted from the correctional system, status offenders and youth who are adjudicated for committing serious misdemeanors, felonies and violent crimes.

A comprehensive array of services is needed to meet the diverse needs of emotionally disturbed juvenile offenders. Needed services include a range of nonresidential services such as individual and family therapy, home-based services and day treatment and a range of residential services such as therapeutic group care and residential treatment. These services are all part of the overall system of care for emotionally disturbed children and youth, and have been previously described. Some of these service components may be designed specifically for emotionally disturbed juvenile offenders. A therapeutic group care program, for example, might be fashioned to meet the special needs of this population. The Treatment and Rehabilitation for Youth (TRY) Program at the Mendota Mental Health Institute in Madison, Wisconsin provides intensive mental health treatment and a range of other services in a secure setting to emotionally disturbed, aggressive youngsters (Buzogany, 1985). In other cases, emotionally disturbed juvenile offenders may be served by the same programs and resources that serve emotionally disturbed children who are not offenders or involved with the legal system.

Juvenile justice agencies also operate detention centers which provide short-term placements pending evaluation and disposition, and training schools which are longer-term correctional facilities for youth. A range of other activities aimed at the prevention of delinquency are undertaken by the juvenile justice system. Current trends in the juvenile justice system include diversion programs to keep youth out of the correctional system and deinstitutionalization with the concomitant development of community-based alternatives for juvenile offenders. Community-based work and restitution programs, decriminalization of status offenders and separating youngsters from adults in jails are all approaches currently meeting with success (Shore, 1985).

The need for better interface between the mental health and juvenile justice systems has become increasingly apparent (Isaacs, 1985). Emotionally disturbed juvenile offenders have the same basic needs as the broader population of concern. These needs are represented by the seven dimensions in the system of care. Ideally, these needs will be addressed by juvenile justice and mental health agencies in a collaborative relationship. In fact, all agencies within the system of care must coordinate their services to more effectively meet the needs of emotionally disturbed juvenile offenders. Youngsters involved with the legal system represent a significant subgroup of the population of severely emotionally disturbed children. Thus, all agencies providing juvenile justice services should be enlisted as partners in the system of care.

VOLUNTEER PROGRAMS

Volunteers can be a very useful resource in the development of service systems. Volunteers can be used in a variety of roles, ranging from providing direct services to helping to raise funds and identify needed resources.

Parent aide programs were already identified as one service generally provided by volunteers in the social service dimension. This program involves the use of trained volunteers to work with abusive or potentially abusive parents. Volunteers are also used to serve as big brothers and big sisters, to be tutors, to assist youngsters with efforts to find and maintain employment, and to assist child care or teaching staff in a variety of programs and settings.

In addition, volunteers can be used to provide transportation, to assist with data collection and clerical tasks, to help in problem solving, to organize and conduct particular activities, and to assist in raising money or identifying resources for special purposes. The range of roles that volunteers can play is extensive, and the types of skills and talents that volunteers can bring to the system of care are wide-ranging.

Volunteers can help to stretch agency resources, can provide many valuable services, and can also help to establish positive relationships with individuals and organizations in the community. They represent a valuable resource that has not been fully utilized in the human services, particularly on behalf of emotionally disturbed children.

As a summary, all the components of the system of care, organized by dimensions, are presented on Table 9.

TABLE 9

COMPONENTS OF THE SYSTEM OF CARE

1. MENTAL HEALTH SERVICES

Prevention
Early Identification & Intervention
Assessment
Outpatient Treatment
Home-Based Services
Day Treatment
Emergency Services
Therapeutic Foster Care
Therapeutic Group Care
Therapeutic Camp Services
Independent Living Services
Residential Treatment Services
Crisis Residential Services
Inpatient Hospitalization

2. SOCIAL SERVICES

Protective Services
Financial Assistance
Home Aid Services
Respite Care
Shelter Services
Foster Care
Adoption

3. EDUCATIONAL SERVICES

Assessment & Planning
Resource Rooms
Self-Contained Special Education
Special Schools
Home-Bound Instruction
Residential Schools
Alternative Programs

4. HEALTH SERVICES

Health Education & Prevention
Screening & Assessment
Primary Care
Acute Care
Long-Term Care

5. VOCATIONAL SERVICES

Career Education
Vocational Assessment
Job Survival Skills Training
Vocational Skills Training
Work Experiences
Job Finding, Placement & Retention Services
Sheltered Employment

6. RECREATIONAL SERVICES

Relationships with Significant Others
After School Programs
Summer Camps
Special Recreational Projects

7. OPERATIONAL SERVICES

Case Management
Self-Help & Support Groups
Advocacy
Transportation
Legal Services
Volunteer Programs

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V. MANAGEMENT OF THE SYSTEM OF CARE

The previous chapters have described the principles and components of an overall system of care. The development of strong components is undoubtedly the most important aspect of developing an effective system. Another important aspect, however, is insuring that the system is managed in a clear and consistent way to assure that youngsters and families receive the services they need in a coherent and coordinated manner.

Proper system management should insure good coordination between components of the system. Such coordination is necessary because most youngsters require services from more than one component at a particular point in time. For example, a child may be both in therapeutic foster care and day treatment. The same child may participate in a special recreational program, and may require transportation in order to participate in this program. In addition, the child may be involved in family therapy with his or her biological parents in an attempt to resolve problems and achieve a reunification of the family. Only in a well-managed system would it be possible for one youngster to receive all of these needed services, and particularly to receive them in a manner that produces coordinated efforts by different professionals and agencies to achieve the same goals. Obviously, the close involvement of a case manager is critical to insure that this occurs.

Effective system management should also insure that as a child's needs change, he or she will be able to easily move into different services, or that existing services will adapt to the new needs. The same child described above, for example, may experience a crisis. This may strain both the foster parents and the day treatment program. In an effective system, it would be possible to provide additional assistance to the foster parents and the day treatment program. This may be in the form of a crisis counselor who goes out to the home to work with the youngster and the foster family and who also works with the day treatment program. As the crisis is resolved and the child progresses, the child may be ready to leave day treatment and enter a less restrictive special educational program with continued involvement by the child's therapist from the day treatment program. The arrangement of this new set of services, again orchestrated by the case manager, constitutes another test of the flexibility and responsiveness of the system. A further test may come a few months later when the child is returned to the biological parents with special assistance in the home. Within an effective and responsive system of services, these changes can be made relatively rapidly and in a nondisruptive manner to keep pace with the changes in the child's situation and needs.

The entire focus on building comprehensive and responsive systems of service is new, and most of the emphasis in the field has been on securing the service components that have been described. Much less attention has been paid to the issue of management of the system. Now, however, as progress is being made to develop a range of services, more attention must be focused on system management issues. While there are no hard and fast, tested solutions in this area, this chapter presents several approaches.

STATE-COMMUNITY RELATIONSHIPS

A major issue with respect to system management is the relationship between state level and community level agencies in managing the system. This includes such questions as the extent to which fiscal resources are controlled at the state level or community level, the degree of flexibility that communities are allowed to develop systems tailored to meet the specific needs within their area (and to take advantage of specific resources within their area), and the degree to which decision making takes place at the community level versus the state level.

As Behar (1984) indicates, "children are best served close to their own communities to maximize the possibility of family involvement in services and to allow for reintegration of the child into his or her natural environment." This suggests that management of the system, in order for the system to be able to be most responsive to the needs of the child and family, should also be at the community level.

While the community should most logically be responsible for system management and coordination, the state must also play a major role in systems of care. The role of the state in relation to the community should be to share in providing resources for the system, to establish standards for communities to meet in developing services, to monitor and evaluate the performance of communities, to establish policies and procedures to facilitate effective service delivery, and to provide consultation and technical assistance to help communities. States may also provide certain limited services that are best provided at the state level, either because they are extremely specialized or deal with problems too low in prevalence to support community level efforts. Overall, the role of the state should be to promote the development of strong and effective community-based systems of services.

If communities are to manage the system of care, it follows that most of the resources should be controlled at the community level. Further, communities should have both the responsibility and the authority to make decisions on individual youngsters. Policies should create incentives for communities to accept responsibility for serving youngsters within their local areas rather than send them to placements out of their immediate communities. While states should and must establish standards and monitor compliance with those standards, they should allow communities maximum flexibility to develop their systems in accordance with their own special needs as long as careful planning is done, the overall plan meets state guidelines, and clear rationales are provided for community actions. This may mean, for example, that one community will elect to focus very heavily on therapeutic foster care services, while another may emphasize therapeutic group care. As long as clear and logical rationales are provided, communities should have the flexibility to make such choices.

In several states, such as Alabama and Nebraska, models of systems of care have included services to be provided at the local community level, other services to be provided at the multicommunity (or regional) level, and other services to be provided at the state level. Such approaches are reasonable, particularly in states that are not densely populated and that cover large geographical areas. In such states, for example, certain specialized and expensive services such as secure residential treatment may not be able to be supported by each community. Nor would there necessarily be a need for each community to have such a program because of the limited number of youngsters who need it.

The development of regional and state services in these instances is justified, and does not necessarily conflict with a community-based approach to management. With such an approach, communities could still control admissions and discharges to the regional and state programs or facilities. Also, incentives can still be in place to encourage communities to serve the youngsters locally and, if that is not possible, to work with the residential placement to try to return the youngster to his or her home as soon as possible.

An example of the use of some centralized state services in addition to community services is provided by North Carolina. For placements in the Whitaker School, the most intensive residential treatment program in the state for emotionally disturbed adolescents, the state is divided into four regions. Each region, through a multi-agency committee, controls the admissions and discharges of six youngsters into Whitaker School. Close working relationships are maintained between the regional groups and the residential program. Once a region has made its six placements, the only way it can make an additional placement is by bringing a child back home. This creates an incentive for discharge, and reduces the likelihood that a community will "warehouse" a youngster for an extended period of time in a state facility that provides a "free" service to the community.

Within many states, services provided by state agencies are delivered on a regional basis. This regionalization can facilitate the establishment of community-based systems of care. However, in some states, the various child-serving agencies may divide the state into regions differently. This creates a system obstacle to agencies working together effectively at the local level and to the establishment of effective community-based management of the system of care. This problem may be averted, to some extent, in states that have a consolidated children's agency. In these cases, most of the services provided to children are under the auspices of a single consolidated children's agency. The structure of the state system and the approach to regionalization should be considered in planning approaches to management of the system of care.

ALTERNATIVE MODELS FOR SYSTEM MANAGEMENT

Within an overall framework of community-based system management of the system of care, there are three basic approaches that can be taken. These approaches include management by a consolidated agency, management by a lead agency, or management by multiple agencies through formal agreements.

The issue of management is perhaps most easily solved in states that have either a consolidated children's agency or a quasi-consolidated agency. A consolidated agency provides all children's services, while with a quasi-consolidated agency almost all of children's services are provided by one agency, but typically responsibility for certain services, such as mental health, is divided between two agencies (Isaacs, 1984). Connecticut, Delaware and Rhode Island are examples of states that have developed consolidated agencies at the state level to administer children's services. Quasi-consolidated agencies can be observed in Florida and New Hampshire.

Since in these cases one agency controls the provision of most services (either directly or contractually), this is the logical agency to manage the system. The coordination task is easier because so many of the services are provided by or funded by one agency. It should be noted, however, that even where there is a consolidated children's agency, certain services such as education and recreation are typically provided by other agencies.

In a system with management by a consolidated agency, management on a case by case basis frequently becomes vested in a team of case managers. These case managers can either be employees of the public agency or employees of a contracted agency. The case managers gain much of their ability and authority to organize a treatment plan and a set of services on behalf of individual youngsters by working under the auspices of the community level unit of the consolidated state agency.

Such an approach requires that there is both a consolidated or quasi-consolidated children's agency and a community or regional structure for the operation of that agency.

A second approach is to designate a single agency as a lead agency for management of the system of care. This can be accomplished through agreement by all agencies involved. In this case, it is essential to have a clear specification of the roles and responsibilities of each agency and a willingness to cooperate from all agencies. In some cases, the designation of a lead agency is mandated either by the legislature, the court or a high level of the state executive branch. For example, in North Carolina the Division of Mental Health, Mental Retardation and Substance Abuse was designated to be the lead agency for services to be provided to youngsters certified as members of the Willie M. class (Behar, 1985).

Much as with the consolidated agency approach, the day to day management of the system in a lead agency approach is often done by a team of case managers working as part of the lead agency or under contract to the lead agency. The case managers have the responsibility for insuring that the system operates in a flexible manner that is responsive to the needs of the clients.

Where an agency has been designated as a lead agency on a voluntary basis through agreement by community agencies, the same agency may not in fact be so designated in another part of the state. In one part of the state, the mental health agency may be selected as the lead agency while in another area the social service agency may be selected. The authority of the lead agency in this situation stems from the voluntary cooperation of the child-serving agencies rather than from a mandate.

The designation of a lead agency for purposes of developing an effective system of care for emotionally disturbed children usually involves defining the youngsters to be served according to some specific criteria. In North Carolina, the group is defined as those youngsters who have been certified as Willie M. In initial system development efforts in Florida, the group of youngsters is defined as those who have been reviewed by a committee and found to be in need of residential services. These relatively restrictive definitions tend to exclude other youngsters who need an integrated system of service as well, and in both states (as well as other states) efforts to broaden the definition are under way. However, as a starting point, particularly with limited resources for case managers, the focus on the more seriously disturbed children can be a good way of beginning to implement a coordinated system of services.

The third system management approach involves management of the system by multiple agencies. Under such an arrangement, agencies clearly define their roles, responsibilities and resource contributions. They may jointly fund case manager positions to work with individual clients, and they may jointly supervise the individuals within these positions. Ohio provides an example of system management by multiple agencies. In 1984, the Governor issued an executive order establishing an interdepartmental "cluster" system to address the needs of youth with multiagency needs. Representatives of all key child-serving agencies meet regularly at the local and state levels to review individual cases of children who the system has not adequately served, and to develop plans to meet the needs of these children and their families. The cluster system involves joint funding of needed services as well as collaborative planning and service delivery.

This approach requires careful planning, good problem solving mechanisms for instances in which conflicts arise, and mutual respect among agencies for the contributions and philosophies of each group. Such multiagency approaches can be focused on management of particular collaborative programs, such as day treatment, rather than on management of entire systems of service.

The challenges involved in effective interagency collaboration are substantial. Differences in philosophy, turf issues, scarce resources and other environmental and organizational factors often present formidable barriers to interagency coordination and to multiagency system management (Stroul, 1983; Isaacs, 1983a). Based on an analysis of interagency coordination and services integration efforts, Isaacs (1983b) concludes that "the development of well-conceived, viable and continuing networks demands long periods of time and high levels of individual and agency commitment."

THE ROLE OF CASE MANAGEMENT AND CASE REVIEW COMMITTEES

Case management plays a critical role in all three system management approaches. Case managers are the "glue" which holds the system together, assuring continuity of services for the child and family. Whether a consolidated agency, lead agency or multiagency management model is used, case managers see to it that the various service components are coordinated and that service needs are assessed and reassessed over time.

The functions and responsibilities of case managers, reviewed earlier, include a number of activities which bring the multiple components and agencies within the system of care together. These include coordinating the comprehensive interagency assessment of the child and family's needs, arranging for needed services, and linking the various services and agencies.

These functions serve to "systematize" the system of care. Further, the case manager is the fixed point of responsibility for monitoring the adequacy of services and for assessing the appropriateness of services. Thus, the case manager is instrumental in assuring that youngsters receive the services that they need and that services are changed as the needs of the child and family change.

Some states and communities have been experimenting with case review committees as an additional management structure (Friedman, 1985). Such committees are used to make or review decisions about appropriate treatment or placement for youngsters in order to insure that the rights of children are protected and that decisions are in the child's best interests.

The group process is used, in particular, for decision making with regard to the most expensive and restrictive placements which involve removal of the child from the home. In such cases, the potential consequences to a child and family of removal from the home are considered to be too great to entrust that decision to any single individual, regardless of the training and experience of that individual. The committee review process can bring together agency people with different perspectives and professionals with different training to review referrals for placement in residential settings. The process can also include the family and child advocates to insure that the best information is presented and all views are represented.

In some states such a process takes place at the state level while in other states it takes place at the community level. It is strongly recommended that such a review process be conducted at the community level. This contributes to community awareness of needs and to community acceptance of responsibility for serving their youngsters. It also brings together the individuals from the community who best know an individual youngster.

As a part of the process of facilitating the acceptance of responsibility at the community level, some states specifically allocate financial resources to communities to be used to serve especially difficult children. These resources are typically allocated based on the percentage of the state's children in each community or region. This process then enfranchises communities to make decisions about their own youngsters. It also creates incentives to be prudent in placement decisions, since any money that is saved can be used to serve additional youngsters.

In some states, particularly where there is not a consolidated or quasi-consolidated children's service agency, decisions about residential placement are made according to different procedures by different agencies. For example, the child welfare agency may use a different set of procedures for decision making than the mental health agency uses. Such an approach runs the risk of inadequately protecting the rights of children since the procedures used vary not as a function of children's needs but rather their agency affiliation. This approach can also be inefficient, resulting in agencies competing with each other to literally "pass the buck" for paying for services rather than cooperating.

A committee, or some individual or group, also needs to be involved in the continual monitoring of the progress of youngsters who have been placed in very restrictive settings. Often, when the same case review committee which has the responsibility for decision making about entry into the placement is also given monitoring responsibility, the monitoring of progress gets neglected. This can contribute to excessive lengths of stay and inadequate protection of the rights of youngsters. Case managers can again play a major role to insure that progress of youngsters is carefully monitored. This should be done through a combination of written reports from the placement setting and actual visits to the youngsters. However, procedures should be established to insure that the progress of youngsters is reviewed not just by an individual but also by a group. The logical group to conduct such a review is the same committee that originally reviewed the application for residential placement, as long as it can be insured that the review process of youngsters in placement will not be neglected.

The establishment of decision-making and case review processes is an important and often overlooked aspect of system management. It is essential for states to address this issue within the context of the overall goal of promoting systems of care, and within the requirement that the rights of children be protected and that they not be placed in restrictive settings without having an adequate opportunity in less restrictive settings.

At this point in the development of systems of service for emotionally disturbed children, there has not as yet been enough experience to recommend a single approach to system management. This is particularly the case because of the different agency configurations existing in different states, the variety of ways in which states have attempted to regionalize their services, and the differences in population density and geography.

Several points appear to be important, although they have not yet been empirically tested. It seems essential that whatever management approach is selected, it should be community-based. Trying to manage a direct service system for youngsters in communities across a state from a state office is cumbersome and inefficient. Further, centralized state level management does not create a sense of commitment in communities for accepting responsibility for serving their children.

It also seems clear, and has been a consistent theme of this monograph, that whatever approach is taken must involve the close cooperation of agencies including not only the mental health, health, social service and juvenile justice agencies but also the school system. Such cooperation is needed both for developing and implementing the component parts of the system and for management of the overall system.

Finally, there are increasing indications that case managers are a key component of any attempt to make a system truly responsive to the needs of the individuals it is designed to serve. Behar (1985) has called it "the most essential unifying factor in service delivery," and it seems clear that for a system to be effectively operated, there should be case managers who can pull services together from a variety of sources to meet the needs of individual clients.

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VI. STRATEGIES FOR DEVELOPING SYSTEMS OF CARE

As noted earlier, conceptualizing a system of care model is only a preliminary step in the system improvement process. The real challenge for states and communities is to transform their system of care plans into reality. This chapter outlines a number of specific strategies and approaches that might be used to translate plans into functioning networks of services for severely emotionally disturbed children and their families.

CASSP is a "system change" program, one which was modeled after similar system change initiatives. One such initiative is the NIMH Community Support Program (CSP) which is designed to assist states to develop systems of care for adults with long-term mental illness. Another is the NIMH-sponsored Most In Need (MIN) Program which involved a number of local demonstration projects to create integrated systems of care for children with multiple handicaps. Both of these programs have emphasized the use of a range of strategies to create significant changes in the service delivery system, changes which would favor the provision of comprehensive, coordinated services to the target population.

In order to capitalize on the experience of these and other system change programs, several analyses have been undertaken (Stroul, 1982, Stroul, 1983). Through these analyses, the experiences and lessons learned by the participating states and communities have been documented. Most importantly, the analyses have identified and described the strategies and approaches used to promote system changes. Thus, there is a wealth of knowledge and experience that states and communities may draw upon in their current efforts to develop systems of care for emotionally disturbed children and youth. As a technical assistance resource for states, a workbook detailing CASSP system change strategies and an accompanying planning protocol was developed by the CASSP Technical Assistance Center (Stroul, 1985). The strategies outlined in this chapter are described in detail in that document. It should be noted that while the strategies are described from the state perspective, they are by and large directly applicable to communities that are engaging in system of care development efforts. Similar activities may be undertaken within a community or a service area that wishes to create more comprehensive, better coordinated systems of care for the target population.

The CASSP strategy, from the Federal perspective, involves providing grant support along with technical assistance to state mental health agencies or to the state children's agency that has primary responsibility for children's mental health services. The state agency then implements a planning and strategy development process designed to develop systems of care for severely emotionally disturbed children and youth throughout the state. This "statewide system improvement approach" involves activities occurring at the state level that are directed at making a range of administrative, legislative, budgetary and programmatic changes that are needed to improve the service system. Additionally, the state agency stimulates and assists in community level activities designed to develop or improve systems of care for the target population. CASSP rests on the assumption that these state activities will lead to the desired outcomes -- first, necessary system changes and, ultimately the improved availability of comprehensive, coordinated systems of care.

What kinds of activities might ultimately result in system of care development? What can a state or a community actually do to affect system changes? CASSP strategies are defined broadly as:

Planned actions that the mental health agency can take, in collaboration with other appropriate organizations and groups, to promote the development of systems of care for severely emotionally disturbed children and youth.

Each state or community involved in a CASSP-related initiative will select system change strategies that are most appropriate for its particular environment and circumstances. Nevertheless, the experience of other system change programs suggests the types of strategies which are most likely to have a broad impact. These system change activities fall within six major areas including:

- Planning and needs assessment,
- Modifying the mental health system,
- Interagency collaboration,
- Technical assistance and training,
- Constituency building, and
- Local system development.

It should be noted that these categories represent not alternative strategies, but rather complementary strategies. In order to develop effective systems of care, states and communities should be selecting and implementing strategies from each of these categories, varying the emphases, strategy types and sequencing to conform with the particular environment.

Within each category, there are innumerable strategies that states or communities may select. Previous analyses of system change programs have shown that states generally develop a "master plan" or blueprint which establishes a framework for their system improvement initiatives. Specific strategies, then, are designed in accordance with this master plan. Again, the precise set of strategies selected, the timing and sequencing of various strategies, and the level of effort devoted to various strategies are dependent upon state-specific needs and circumstances. A discussion of the strategies within each broad area follows.

STRATEGIES FOR PLANNING AND NEEDS ASSESSMENT

The strategies in this first category include a number of basic steps taken by states to initiate the system change process. The first step is the establishment of a focal point at the state level to initiate and coordinate system development activities. Generally, states either identify or establish a state level administrative unit within the state mental health agency. This unit, staffed by individuals with expertise in child mental health, serves as the focal point for CASSP-related activities.

In order to begin to address the needs of emotionally disturbed children, states proceed to implement a planning process. The planning process includes such tasks as:

- Defining the target population,
- Assessing the characteristics and service needs of the target population,

- o Defining the nature and components of the desired system of care, and
- o Assessing available services and identifying service gaps and needs.

Based on these early planning tasks, goals and priorities for the system improvement effort are then established. This planning process should be accomplished with broad professional and consumer participation, with input and involvement sought from health and human service agencies, professional and provider organizations, parent and family groups, and child advocacy groups. It is apparent that these planning strategies are also relevant at the community level.

The analyses have shown that almost all states involved in system change select a strategy aimed at influencing the state planning process. This may take the form of drafting a section of the state mental health plan dealing with children; preparing a long-range comprehensive plan for system of care development; working to establish children as a priority population in the state plan; or influencing regional and local planning processes to promote system of care development.

Organizing, serving on or consulting with a wide variety of task forces and advisory committees is a second type of strategy within this category. Task forces or committees are organized around a specific task or issue in some cases, for example to develop guidelines and standards for day treatment programs for children and youth. In other cases, committees with broad representation are organized with a more general purpose, e.g., to advise on mental health services for children, in hopes that they will succeed in influencing the level and nature of services provided to the target population.

Surveys and needs assessments related to both the target population and the service system are a third type of strategy in this area. Surveys and assessments to identify, locate and describe severely emotionally disturbed children have been undertaken, and attempts have been made to establish their service needs with hard data. A number of studies have demonstrated that many children in hospitals and residential treatment centers could be treated in less restrictive settings given the appropriate community supports (Behar, 1986; Knitzer, 1984). In addition, several states have conducted assessments of the current availability of system of care components.

The data from both types of assessments are generally used to impact planning, regulatory, legislative and budget processes. The previous analyses have revealed, however, that complex and expensive needs assessments are neither necessary nor cost-effective for a system change effort. Rather, data collection should be limited to target information that has specific utility in planning and implementing system change strategies.

STRATEGIES TO MODIFY THE MENTAL HEALTH SYSTEM

Strategies in this area are specific steps that may be taken to address the reforms needed in the mental health system to promote system of care development. They include a range of actions to ensure that mental health resources (funds, staff, programs and facilities) are used to better meet the needs of severely emotionally disturbed children and youth. The basic goal of such strategies is to shift the philosophy, policies, practices and resources of the mental health system to promote community-based, child-centered systems of care.

A wide variety of strategies can be used to make the state mental health system more responsive to the needs of children and youth. These include strategies devised to make regulatory, legislative, budgetary or programmatic changes that will promote and facilitate the statewide development of community-based systems of care.

Strategies to address regulatory processes comprise one group included in this area. These methods involve developing or participating in the development of program or staffing guidelines and standards for system of care components, e.g., developing standards for therapeutic foster homes. States may also focus on revising the rules and regulations governing state funding of mental health services to make systems of care for children a top funding priority.

Strategies to impact the legislative process can include methods such as drafting and submitting bills for system of care components and consulting with legislators and legislative committees regarding the needs of the target population. Strategies to affect budget processes also fall in this area. They include a range of persuasive techniques to influence the budget preparation process within the mental health department as well as the preparation of special legislative budget issues and packages. Depending upon the circumstances, strategies may attempt to access new monies for system of care development or they may pursue reallocation of resources for the development of more appropriate, community-based children's services.

Finally, strategies in this area include the creation of new services, programs or mechanisms to promote system of care development. Examples include adding "home-based services" as a service that the state can contract and reimburse for or designing a program of grants to counties for system of care development projects.

At the community level, similar reforms can be instituted to promote system of care development. County boards or commissions, for example, can institute regulatory or budgetary changes that encourage the development of system components and of multiagency service networks.

STRATEGIES FOR INTERAGENCY COLLABORATION

The broad range of needs and multiproblem nature of the CASSP target population make it essential that mental health service delivery be closely integrated with education, child welfare, juvenile justice, retardation, health and other services. Therefore, strategies for coordination and collaboration with those other agencies and systems which impact on emotionally disturbed children are essential.

Strategies in this area include measures to: 1) educate other agencies about the needs of emotionally disturbed children, 2) advocate for the target population in an attempt to persuade other agencies to join in the system of care development process, 3) share resources among health and human service agencies for system of care development, and 4) create a network of agencies committed to addressing the needs of severely emotionally disturbed children.

Strategies in this area include organizing, serving on or consulting with a wide array of interagency task forces and committees. Some of these might be initiated by the state legislature or the Governor, while other interagency task forces may be a staff initiative. Regardless, it has been demonstrated that the success of interagency task forces depends on obtaining the right level of representatives (those with access to power, but close enough to affect operations), ensuring meaningful tasks and roles, and providing evidence that recommendations are taken seriously.

power, but close enough to affect operations), ensuring meaningful tasks and roles, and providing evidence that recommendations are taken seriously.

At the community level, it is essential to create a network of agencies to collectively address system of care development. This interagency network can serve as the focal point for local planning efforts for the system of care, and can provide system level coordination for services to be provided within the system of care. Such networks have been shown through the NIMH Most In Need Program to create a collective commitment among child-serving agencies to emotionally disturbed children, and to provide a mechanism for joint planning and service delivery (Stroul, 1983).

Interagency or interprogram agreements comprise a group of strategies used frequently to induce agencies to be collectively more responsive to the target group. In some cases, the agreements may be general expressions of affiliation or joint purpose, whereas in other cases they have documented work plans and detailed processes for providing services. It is important to recognize that interagency agreements negotiated at the state level do not always filter down to the local level and thus do not necessarily result in change in service delivery or exchange of funds. Interagency agreements should be accompanied by provisions for implementation throughout the system and for any requisite technical assistance.

Strategies to mobilize resources for system development include actions to access new resources, to encourage reallocation of resources or to foster more appropriate use of resources for severely emotionally disturbed children. Medicaid is the focus of resource development strategies, and some states are working with the state health agency to liberalize service definitions to allow Medicaid reimbursement for such services as day treatment or case management. Strategies involving interagency training are also used by states to promote system of care development. Training materials and programs might be used with the staff of other agencies,e.g., education, to help them deal more effectively with emotionally disturbed children and their families. Training events might be co-sponsored by two or more child-caring agencies to foster better communication and coordination of services.

STRATEGIES FOR TECHNICAL ASSISTANCE AND TRAINING

As an integral part of their system change efforts, states provide technical assistance and training to a variety of organizations and agencies involved in providing services to children and adolescents. Strategies for training and technical assistance are directed at both state and local levels, and are designed to provide information on the concepts and goals of system of care development, child mental health needs, potential funding sources and promising models and approaches. Additionally, states often provide technical assistance to other states.

A broad array of technical assistance and training approaches are available (Friedman, 1986). In fact, many states and communities have relied heavily on a technical assistance and training approach to shift the mental health and larger service system in the desired directions. Surveys and assessments are among the methods used to plan technical assistance and training initiatives. Training needs assessments might be undertaken or more informal methods may be used to identify all the groups needing training and consultation relative to system of care development. Based on these assessments, training and technical assistance may be provided to diverse groups including advisory boards, mental health and child-caring agency staff, government officials at all levels, judges and juvenile justice system staff, legislators, families, consumers, advocates, university students and faculty, etc.

Training strategies often involve sponsoring, co-sponsoring, organizing or contracting for statewide or regional conferences, workshops and seminars. Such conferences might focus on the entire system of care, or might concentrate on key system of care components or issues. Ongoing training programs might be designed and conducted such as a statewide training program for case managers. Some states might choose to base their training approach on the use of a demonstration program. In this case, the model program is used to provide on-site experiential training on how to implement the component. Often, these training experiences are followed by technical assistance provided by demonstration program staff and state staff.

Technical assistance may be provided through a variety of mechanisms. State planning processes and monitoring site visits may afford opportunities for reaching local programs and offering consultation regarding system of care development. Telephone and on-site consultation are frequently used methods to assist local communities in addressing the needs of severely emotionally disturbed children. Training materials, such as videotapes, may also be used to depict the concept and components of the system of care, and can have broad educational applications.

STRATEGIES FOR CONSTITUENCY BUILDING AND PARTICIPATION

In order to have a substantial and lasting impact on the mental health and human service system, the importance of a strong and vocal constituency cannot be underestimated. Strategies in the constituency building area are directed at three primary purposes. First, mechanisms are used to include key individuals and groups in planning for the target population at state and local levels. These key individuals and groups include parents, consumers, professionals and child advocates as well as private sector providers and organizations. Second, strategies are needed to stimulate the development of new advocacy groups for children and youth and to facilitate the advocacy activities of both existing and new groups. Finally, states are likely to adopt strategies to generate public awareness and support for system development activities on behalf of children and youth.

In order to solicit the participation of interest and constituency groups in planning and policy development, states may use existing task forces, committees or advisory bodies as forums or they may create new structures to address system of care planning and programming. Parents, consumers, professional and child advocates may be invited to join these groups in order to incorporate their perspectives in the planning and development of systems of care. States may also reach out to the private sector, encouraging the participation of private nonprofit providers, private profit-making providers, charitable organizations and private industry. Strategies to establish a partnership with the private sector should be implemented in order to work collaboratively toward system of care development.

To promote the development of new advocacy groups and facilitate advocacy activities, states can provide either material or nonmaterial support. Material support for advocacy provided by states has consisted of sponsoring statewide and regional advocacy conferences and workshops, and providing funds for a variety of advocacy projects. For example, a strategy used in the past has been to contract with the Mental Health Association or the Alliance for the Mentally Ill to organize new family, parent or consumer groups or to coalesce advocacy groups into a statewide coalition. Material support has also involved providing stipends to consumers or family members to sponsor their participation at conferences and contracting with advocacy groups to operate special programs, such as technical assistance to other groups.

Nonmaterial support provided by states generally involves supplying information such as legislative and budget information, including "alerts" on key bills and upcoming hearings. Advice can be supplied to advocacy groups to assist them in becoming incorporated, planning conferences or identifying resources. Technical assistance, training, general encouragement and moral support are among the other possible forms of nonmaterial assistance.

Public awareness and support may be sought through media exposure, workshops and presentations to government, civic, volunteer and professional groups. Such strategies are designed to educate the larger community about the needs of severely emotionally disturbed children and about the types of services that may be provided through a system of care. These strategies often result in encouraging individuals and groups to become involved in the constituency for emotionally disturbed children, advocating for funds and services at state and local levels.

STRATEGIES FOR LOCAL SYSTEM DEVELOPMENT

The development of systems of care in local communities is the objective of all the strategies described above. Still, there are a number of additional strategies that may be adopted in order to specifically promote the development of components and systems at the local level.

By far the most widely used strategy in this category centers around the use of model or demonstration programs. Model programs are used for a variety of purposes. They provide working examples of community-based service approaches to persuade legislators and other decision-makers of their viability. By drawing attention to the models, states are able to sensitize other communities to the need for similar programs. Models are also used as a learning base for future plans, policies and programs. Another widespread use of model programs is as a training and technical assistance resource. A number of states adopt a demonstration/program development approach. This strategy involves developing demonstration programs in one or more areas, and over time, proceeding to "replicate" or develop programs in additional communities with appropriate variation to meet local needs.

Direct state funding of system components through contracts or grants is another approach available to states to promote local program development. One strategy consists of providing limited funds to each county or service area to fill one or two system gaps and to serve as an incentive to address system of care issues. Such funds may also be used to assist communities to establish interagency networks to plan and coordinate systems of care. The interagency networks can serve as a focal point for future system development activities at the community level. Other direct funding strategy options include contracting with local agencies on a broad scale to provide a range of services, awarding grants to develop and operate system components, and providing state funds for innovative system components.

Performance contracts and other regulatory mechanisms are also used to promote local system development. States may require the development of systems of care through performance contract provisions or through modifications in rules, regulations and guidelines. For example, states may create relatively rapid changes in service delivery by shifting funds from support of traditional services to support of community-based service alternatives.

States without the resources to provide much direct funding for system of care development may rely on a training and staff development approach to improve local services. In addition, research and evaluation can be used as a strategy in the local program development area. Research and evaluation projects are often tied to demonstration programs, and may explore changes in service availability, utilization or coordination; changes in child and family functioning; cost-effectiveness; and other key aspects of system of care development. Research and evaluation results are often used to generate legislative and administrative support for expanded programming.

All strategies that are used to promote local system development should create incentives for local communities to take responsibility for serving emotionally disturbed children and their families. States may adopt strategies that provide communities with not only the responsibility, but the flexibility and decision making authority to create systems of care that are responsive to their needs and are in all respects community-based.

In planning system change initiatives, each state or community faces a unique set of organizational, political and economic circumstances. These conditions shape or determine the types of system change strategies that can be successfully employed. The strategies used to promote system of care development must be appropriate to the particular contextual circumstances within a state or community.

There are a number of environmental factors or conditions which play a key role in shaping the nature and types of strategies adopted. These factors include the history of the state which determines its stage of development vis-a-vis system development, the organization of the service system which determines the level or levels efforts are focused on, the availability of resources to support system development which determines the extent to which states can subsidize program development, and a number of others. In order to select appropriate strategies, states must consider these factors and, in effect, "diagnose" their situations. This diagnostic process provides a reasoned basis for determining the types of strategies that would be most productively employed.

State and communities should also approach the selection of system change strategies within the context of the current economic climate, and plan their activities realistically. As noted by Stroul (1985), "the overriding consideration in the strategy selection process should be how to use limited financial and other resources to achieve the most substantial and lasting changes in relation to system of care development for severely emotionally disturbed children and youth."

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VII. SYSTEM ASSESSMENT

This monograph has been prepared to assist states and communities to improve services for severely emotionally disturbed children and adolescents. In general, despite significant deficiencies in the present service systems in many states, there is much to be encouraged about. There has been increased attention paid to the needs of emotionally disturbed children and their families. In particular, there is growing recognition that effective service systems require a range of services and close interagency collaboration. Important progress is being made in developing new service components and in providing case management services to link the various services. Additionally, there is an expanding knowledge base about effective community-based service options, system management and strategies for producing system change.

This concluding chapter reinforces many of the points made earlier by presenting a series of questions to assess systems of care on a statewide or community basis. The assessment questions address the characteristics of an effective system with respect to such areas as the development of a model, planning and decision making processes and interagency relationships. Primarily, these characteristics represent the viewpoint of the authors, based upon their experience. The questions are by no means exhaustive; many additional questions and characteristics may be relevant to assessing systems of care.

The assessment questions are followed by sample worksheets for assessing the status of the development of the various system of care components. The assessment questions and worksheets are presented to summarize the information presented in the monograph and to provide readers with a framework for evaluating the status of the system in their state and community.

ASSESSMENT OF THE CHARACTERISTICS OF AN EFFECTIVE SYSTEM OF CARE

System of Care Model

An effective and responsive system should recognize the need for a range of services, and should be based upon a specific model of a children's system of care. Questions that might be asked to assess the status of either a state of community system are:

- Does a specific model of a system of care for emotionally disturbed children exist?
- If so, does the model include a wide range of both nonresidential and residential services?
- Are there data available on the capacity in each component of the system and on the percentage of the children's mental health budget that goes to each component?
- Is there reasonable balance in the system, with greater capacities in the less restrictive services than in the more restrictive and a significant portion of the budget going for nonresidential services?

Planning for the System of Care

Part of the foundation for an effective system is a carefully developed state plan. Questions that can be asked to assess planning include:

- Is there a clear state plan that has been developed specifically to prevent and treat emotional disturbance in children?

- If so, is the plan the result of interagency collaboration with participation and input from all relevant child-caring agencies?

- Has there also been participation in developing the plan by providers, parents, advocates and consumers?

- Is there a requirement that communities and/or regions within the state develop their own plans for system of care development, and if so, do they receive technical assistance in the formulation of their plans?

- Are community and regional plans closely reviewed with meaningful feedback provided? When community or regional plans are accepted, are they actually used as a basis for system changes?

Community-Based Nature of System

In keeping with one of the core values expressed in this monograph, services should be provided and managed on a community or regional level. Questions that can be asked to assess the community-based nature of the system include:

- To what extent do state policies and practices promote community-based services and the acceptance of responsibility by communities for serving their children locally?

- Are there fiscal incentives for communities to serve children locally?

- What proportion of the state children's mental health budget is controlled at the community versus the state level?

- To what extent are decisions about particular youngsters and services made at the community or state level?

- Are there accountability procedures to maximize the likelihood that communities develop effective systems of service?

Interagency Collaboration

A continuing theme throughout this monograph has been the importance of interagency efforts in the development of effective systems of care. Questions that can be asked to assess interagency collaboration are the following:

- Are there formal mechanisms at the state and community level to insure interagency collaboration in planning and delivering services?

- To what extent does joint funding of programs and services occur?

Coordination and Management of the System of Care

An effective system must be well-managed, with close coordination of services and clear accountability. Assessment questions include:

- Is there a management structure that provides clear roles and responsibilities for different agencies and clear accountability for providing services?

- Are the different components of the mental health dimension coordinated to promote rapid and easy movement from one service to another?

- Are there close linkages among the various child-caring agencies and systems so that youngsters can receive multiple services in a coordinated manner?

- Is there a clear locus of responsibility for insuring that youngsters with multiple needs do, in fact, receive services from all of the relevant agencies?

Treatment Decision Making

Within an effective system, there should be clearly articulated procedures for making decisions about individual youngsters. Such procedures should provide adequate protection for the youngsters while also insuring that their needs are met. Questions that can be asked with respect to decision making are as follows:

- Is there a clearly articulated procedure for treatment and placement decision making for individual children with serious emotional problems?

- Is there consistency between agencies in the procedures that are used for treatment decision making?

- Particularly for decisions about placements in highly restrictive settings, do the decision making procedures involve multiagency and multidisciplinary input?

- Are treatment and placement decisions made on a community level?

- Are family members and youngsters permitted to participate in the decision making process to the extent that they are capable?

- Is there systematic follow up and progress review of youngsters after decisions have been make to place them in restrictive settings?

Training and Technical Assistance

As noted, technical assistance and training are important strategies for promoting the development of effective systems of care. Many states and communities rely heavily on a training and technical assistance approach to foster system development. Questions to assess the training and technical assistance effort include:

- Is there a training and technical assistance plan at the state and community level which outlines training and technical assistance needs and planned activities in relation to systems of care?

- Is there a training and technical assistance plan at the state and community level which outlines training and technical assistance needs and planned activities in relation to systems of care?

- Is consultation regularly provided to key community planners and providers to help strengthen community-based services for emotionally disturbed children?

- Is consultation regularly provided to state level planners and policymakers to enable them to better assess state needs and develop system of care plans and policies?

- Do key individuals at state and community levels receive regular training opportunities?

- Are adequate training and technical assistance provided before new services are initiated and at regular intervals as services are being provided?

- Is information about successful procedures and programs regularly and systematically disseminated throughout the state so that other planners and providers can benefit?

Advocacy and Community Education

As indicated, the development of effective systems requires strong advocacy and community education efforts. Within recent years, there have been significant increases in both advocacy and community education activities related to systems of care. Assessment questions that can be asked are:

- Are there regular attempts to educate the community including representatives of advocacy groups, civic groups and service groups about the needs of emotionally disturbed children and the approach of the community to meet these needs?

- Are there attempts to involve parent, advocacy, civic, professional and other groups in efforts to strengthen the system of services?

- Do public officials and representatives of parent, advocacy, civic and professional groups work in partnership on behalf of children?

- Are there efforts to encourage the development of new advocacy groups to advocate on behalf of emotionally disturbed children, and are there efforts to facilitate the advocacy activities of existing groups?

Standards, Monitoring and Evaluation

Effective systems of service require the establishment of service standards as well as careful monitoring and periodic evaluation of outcomes. Questions that may be asked to assess monitoring and evaluation activities includes:

- Are there guidelines and/or standards for programs and services for emotionally disturbed children?

- Are there guidelines and/or standards for community-based decision making and planning for systems of care?

- Are there regular procedures for evaluating the outcomes and costs of systems, programs and services for emotionally disturbed children?
- Are the results of the evaluations used as part of the planning and policymaking process?

Statutory Base For System of Care

As discussed in the monograph, it is essential that there be an adequate statutory base for delivering services for emotionally disturbed children. Questions that may be asked are the following:

- Is there an adequate statutory base for the provision of services for emotionally disturbed children?
- Is there an adequate statutory base for the protection of the rights of children, particularly with respect to issues such as involuntary hospitalization, treatment in the least restrictive setting and placement on units with adult clients?
- Do the protections include children served both in the public and private sector?
- Are there adequate mechanisms for monitoring compliance with the statutes?

Fiscal Policies

Fiscal policies must not only be consistent with the objectives of the system of care, but should create incentives for effective, community-based systems of service. Assessment of fiscal policies includes the following questions:

- Is there a sufficiently secure and stable funding base for services to encourage providers to develop and continue offering the services?
- Do the funding mechanisms provide adequate accountability and quality control while still allowing providers sufficient flexibility so that they can provide effective services?
- Do the fiscal policies encourage an adequate balance between attention to immediate needs to provide services and to more long-range system needs to prevent severe emotional disturbance in children?
- Are multiple sources of funding used including Federal, state, local and private sector funds?
- Are there incentives for multiagency funding of system of care components and for creative interagency financing approaches?

Systems of care are constantly evolving, with change and innovation taking place at rapid rates. The challenge facing states and communities is to build effective and responsive systems of service based both on existing knowledge and on creative planning and problem solving efforts. The challenge extends beyond building systems to meet the needs of children and families in 1986 to include laying the foundation for future systems of care. The system of care of the future will require the combined efforts of professional and nonprofessionals, the public and private sectors, and parents, advocates and citizens from all walks of life.

While all of the knowledge needed to effectively serve youngsters with serious emotional problems is not presently available, the most current knowledge and technology is not presently being utilized in most communities. The leadership and commitment to provide comprehensive services and opportunities for children with emotional problems must be developed in order to build effective systems of care.

WORKSHEET TO ASSESS STATUS OF SYSTEM OF CARE
FOR SEVERELY EMOTIONALLY DISTURBED CHILDREN AND ADOLESCENTS

INSTRUCTIONS: THE COMPONENTS THAT COMPRISE A SYSTEM OF CARE FOR SEVERELY EMOTIONALLY DISTURBED CHILDREN AND YOUTH ARE LISTED BELOW. FOR EACH COMPONENT, NOTE ITS CURRENT STATUS, DESIRED STATUS AND POSSIBLE STRATEGIES TO IMPROVE STATUS. THE FOLLOWING RATING SCALE MAY BE USED TO ASSESS EACH COMPONENT. EXPLAIN RATINGS.

1 - COMPONENT NOT PRESENT
2 - COMPONENT MEETS LESS THAN 50% OF THE NEED
3 - COMPONENT MEETS 50% TO 80% OF THE NEED
4 - COMPONENT MEETS MORE THAN 80% OF THE NEED

COMPONENT	CURRENT STATUS	DESIRED STATUS	POSSIBLE IMPROVEMENT STRATEGIES
I. MENTAL HEALTH SERVICES			
NONRESIDENTIAL SERVICES			
Prevention			
Early Identification & Intervention			

COMPONENT	CURRENT STATUS
Assessment	
Outpatient Treatment	
Home-Based Services	

DESIRED STATUS	POSSIBLE IMPROVEMENT STRATEGIES

COMPONENT	CURRENT STATUS
Day Treatment	
Emergency Services	
RESIDENTIAL SERVICES	
Therapeutic Foster Care	

DESIRED STATUS	POSSIBLE IMPROVEMENT STRATEGIES

COMPONENT	CURRENT STATUS
Therapeutic Group Care	
Therapeutic Camp Services	
Independent Living Services	

DESIRED STATUS	POSSIBLE IMPROVEMENT STRATEGIES

COMPONENT	CURRENT STATUS
Residential Treatment Services	
Crisis Residential Services	
Inpatient Services	

DESIRED STATUS	POSSIBLE IMPROVEMENT STRATEGIES

COMPONENT	CURRENT STATUS
II. SOCIAL SERVICES	
Protective Services	
Financial Assistance	
Home Aid Services	
Respite Care	
Shelter Services	
Foster Care	
Adoption	

DESIRED STATUS	POSSIBLE IMPROVEMENT STRATEGIES

COMPONENT	CURRENT STATUS
III. EDUCATIONAL SERVICES	
Assessment & Planning	
Resource Room	
Self-Contained Special Education	
Special Schools	
Home-Bound Instruction	
Residential Schools	
Alternative Programs	

DESIRED STATUS	POSSIBLE IMPROVEMENT STRATEGIES

COMPONENT	CURRENT STATUS
IV. HEALTH SERVICES	
Health Education & Prevention	
Screening & Assessment	
Primary Care	
Acute Care	
Long-Term Care	

DESIRED STATUS	POSSIBLE IMPROVEMENT STRATEGIES

COMPONENT	CURRENT STATUS
V. VOCATIONAL SERVICES	
Career Education	
Vocational Assessment	
Job Survival Skills Training	
Vocational Skills Training	
Work Experiences	
Job Finding, Placement & Retention Services	
Sheltered Employment	

DESIRED STATUS	POSSIBLE IMPROVEMENT STRATEGIES

COMPONENT	CURRENT STATUS
VI. RECREATIONAL SERVICES	
Relationships with Significant Others	
After School Programs	
Summer Camps	
Special Recreational Projects	

DESIRED STATUS	POSSIBLE IMPROVEMENT STRATEGIES

COMPONENT	CURRENT STATUS
VII. OPERATIONAL SERVICES	
CASE MANAGEMENT	
Self Help & Support Groups	
Advocacy	
Transportation	
Legal Services	
Volunteer Programs	

DESIRED STATUS	POSSIBLE IMPROVEMENT STRATEGIES